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Impact of Childhood Sexual Abuse on Women's Coping Skills

Katina Williams

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IMPACT OF CHILDHOOD SEXUAL ABUSE ON WOMEN'S COPING SKILLS

by

Katina Williams, B.S.

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Approved:

_____	_____
Frank Muscarella, Ph.D., Chair Professor of Psychology	Karen A. Callaghan, Ph.D., Dean College of Arts and Sciences
_____	_____
Stephen W. Koncsol, Ph.D. Associate Professor of Psychology	Date

Dedication

To my mother and grandmother, without both of you my passion for psychology and pursing higher education would not have been possible. The way you both have been there for me has been incredible. I could not ask for a better team to be by my side, you both are truly one of a kind.

Grandmother I will miss you always and I will keep everything you have taught me close to my heart.

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Abstract

The purpose of this study was to examine the relationship between personality characteristics associated with coping, healthy psychological functioning, and depression anxiety in a group of women who experienced childhood sexual abuse (CSA). Berliner (2000) and David Finkelhor (1979) defined sexual abuse as involving any sexual activity with a child where consent is not or cannot be given. Studies by Finkelhor (1979) show that 1 in 5 girls and 1 in 20 boys are victims of child sexual abuse. Research shows that child sexual abuse victims exhibit more psychological symptoms and more characterological self-blame that results in the use of more avoidant coping strategies (Arata,1999). Archival data was used from a large online survey about sexual sex-schemas and sexual functioning in women (Hive, 2009). The participants were 200 adult women with a history of childhood sexual abuse and 156 adult women with no history of childhood sexual abuse. The ages of the participants ranged from 18 years old to 69 years old. The participants were from various ethnic backgrounds and sexual orientations. The participants completed the following: demographic questionnaire, childhood sexual abuse assessment, depression scale, anxiety scale, *Sexual Self-Schema Scale (SSSS), and Psychological Strength Scale (PSS).* For women who experienced CSA the scores from the depression scale, anxiety scale, and PSS were subjected to a Pearson's correlations. It was hypothesized that there would be significant negative correlations between depression and anxiety and psychological strengths women who experienced CSA. This hypothesis was not supported. The correlations between depression and anxiety and psychological strength were significantly positive. A series of post hoc analyses were conducted to try and clarify these results. The correlational analyses were conducted on

the group of women who did not experience CSA and a comparison was made between CSA and non-CSA women. The analyses showed that the CSA women and non-CSA women did not differ on the anxiety scale scores, but CSA women did show significantly higher levels of depression and a lower level of psychological strength than non-CSA women. The results suggest that CSA women have lower levels of psychological strengths than non-CSA women. Furthermore, the maintenance of CSA women's psychological strength maybe more psychologically costly. Several limitations with the research were also discussed.

Impact of Childhood Sexual Abuse on Women's Coping Skills

Many abused children cling to the hope that growing up will bring escape and freedom (Herman, 1997). Maltreatment, in general is associated with a number of negative outcomes for children including developmental delay, lower school achievement, juvenile delinquency, substance abuse, and mental health problems. Childhood trauma or maltreatment can take many forms, including physical, sexual, and psychological abuse, as well as neglect. After declining modestly between 2008 and 2011 from 9.3 per 1000 children to 8.8 per 1000 children, the national rate of child maltreatment increased to 9.1 per 1000 children in 2014 and 9.2 in 2015 ("America's Children: Key National Indicators of Well-Being," 2017). The risk of maltreatment is higher for young children, particularly infants. In 2015, the maltreatment rate for children under age 1 was 24.2 per 1000, more than twice the rate for any other age group. Recent increases in the maltreatment rate have been largest for children under age 1, moving from 22.3 per 1000 to 24.2 per 1000 between 2013 and 2015 ("America's Children: Key National Indicators of Well-Being," 2017). Maltreatment rates for children ages 0-17 varied substantially among race and Hispanic origin groups, 1.7 per 1000 children up to 14.5 per 1000 children in 2015 ("America's Children: Key National Indicators of Well-Being," 2017). Overall, trauma maltreatment statistics have found that 25% of children in the United States will witness or experience a traumatic event before they turn four. It is also seen that nearly 14% of children repeatedly experienced maltreatment by a caregiver, including nearly 4% who experienced physical abuse and more than two-thirds of children reported at least 11 traumatic events by age 16 (STATISTICS, 2013).

Childhood maltreatment can also be classified in terms of abuse and/or neglect. Every day in America, 1825 children are abused or neglected. Statistics also show that approximately four to five children die per day as a result of neglect or abuse. It has also been shown that 60% of adults have reported experiencing abuse and other family difficulties in their lifetime. In a nationally representative survey of 12 to 17-year-old youth, 8 percent reported a lifetime prevalence of sexual assault, 17 percent reported physical assault, and 39 percent reported witnessing violence (Kilpatrick DG, Saunders BE. 1997).

Since 2011 there has been an increase in the number of children experiencing maltreatment. The most common trauma in the U.S since 2014 is emotional or psychological trauma. Emotional trauma is the damage or injury to the psyche after experiencing a frightening or distressing event. According to Child Abuse Statistics, neglect makes up for 75.3% of childhood abuse (Child Abuse Statistics, 2015). The second most common form of trauma is physical abuse which is 18% of the childhood trauma population. Physical trauma is seen as a serious injury to the body that can be caused by hitting, kick, pushing, and a variety of other physical interactions. Physical trauma also includes sexual abuse and every year 9% of children are victims of sexual abuse.

Although sexual trauma is an act that is usually done by parents and family. The *DSM*-5 (2013) defines "traumatic stressor" as one in which "any event that may cause or threaten death, serious injury, or sexual violence to an individual, a close family member or a close." In one year, 39% of children between the ages of 12 and 17 reported witnessing violence, 17% reported being victim of physical assault, and 8% reported

being the victim of sexual assault (Finkelhor et al, 2009). According to (Kilpatrick & Saunders, 1997) 4 of every 10 children in America say that they experienced a physical assault during the past year, with one in 10 receiving an assault-related injury. Young children exposed to five or more significant adverse experiences in the first three years of childhood face a 76% likelihood of having one or more delays in their language, emotional or brain development. These issues may affect an individual for the rest of their lives leaving permanent damage in the way they cope with difficult situations.

Early childhood trauma can lead to a number of psychological risk factors or mental health disorders such as depression, anxiety and some psychotic disorders. Research indicates that when trauma occurs in childhood, the impact can impede psychological, emotional, physical, and personality development. According to the American Psychological Association (2008), children and adolescents vary in the nature of their responses to traumatic experiences. The reactions of individual youths may be influenced by their developmental level, ethnicity/cultural factors, previous trauma exposure, available resources, and preexisting child and family problems. However, nearly all children and adolescents express some kind of distress or behavioral change in the acute phase of recovery from a traumatic event. Not all short-term responses to trauma are problematic, and some behavior changes may reflect adaptive attempts to cope with a difficult or challenging experience. This is the main concern as childhood development prepares individuals for young adulthood. Research has also considered that childhood development does not occur in a vacuum. Development occurs within the context of the immediate environment and the extended environment. As highlighted in Bronfenbrenner's theory (1994) of the ecological systems, it is generally accepted that

environmental factors impact a child's development. This is evident, particularly when the environment is dysfunctional, maladaptive, or abusive.

Emotional Abuse

Emotional abuse is just one form of abuse that people can experience in a relationship. Though emotional abuse doesn't leave physical scars, it can have a huge impact on your confidence and self-esteem. According to (Women's College Hospital, 1995) in a study of 1,000 women 15 years of age or older, 36% had experienced emotional abuse while growing up; 43% had experienced some form of abuse as children or adolescents; 39% reported experiencing emotional abuse in a relationship in the past five years.

Emotional Neglect

Cohen, (2013) stated that emotional neglect involves failing to provide emotional support that one should provide, given one's relationship to the other. Emotional neglect is distinctly different from emotional abuse which involves emotional omissions, doing things that can be hurtful emotionally or traumatizing, whereas emotional neglect is omitting to do things that tend to promote emotional well-being.

For example, a child's basic needs as outlined by Christine Cooper's (1985) parenting checklist include basic physical care, affection, security, stimulation and innate potential, guidance and control, responsibility and lastly, independence. Neglect of a child occurs when parents or caretakers are not able to or won't meet the needs of a child. Sometimes this results if they don't have the skills or support needed to do so, sometimes due to problems such as drug or alcohol issues, poverty, and even mental health issues. Children most at risk of being neglected are disabled children, children in care, children

who have experienced other forms of abuse, children from black and mixed ethnic backgrounds, children living in poverty, unsuitable housing or a deprived area. (Thoburn et al., 2000). It is not always possible to identify neglect since there is no single sign that a family needs help. So, professionals wait for an ongoing pattern before stepping in.

Physical Abuse

Miller-Perrin and Perrin, (2013) stated five children die each day from child abuse. Most children who die from abuse are under three years old. Most children are abused at home or by someone they know. They often love this person or are afraid of them, so they do not tell anyone. Physical abuse occurs when a person physically hurts a child causing injuries such as bruises, broken bones, burns or cuts. Some parents or caretakers will go so far as to cause symptoms of illness in a child by giving them medicine they do not need affecting the child's health, this is known as fabricated or induced illness. Some reasons highlighted for physical abuse by adults are comprised of: family or relationship problems, emotional or behavioral problems such as difficulty controlling anger, having experienced abuse as a child, parenting difficulties including unrealistic expectations of children, not understanding a child's needs or no idea how to respond to a child and even health issues. The initial impact of physical abuse on children causes pain and suffering. However, the emotional pain will last long after the bruises and wounds have healed. The longer a child experiences physical abuse, the more serious the impact. Chronic physical abuse can result in long-term physical disabilities, including brain damage, hearing loss or eye damage. The age that the abuse occurs also influences the impact of the damage.

For example, infants who are physically abused are more likely to experience long-term physical effects and neurological alterations such as irritability, lethargy, tremors, and vomiting. In more serious cases where the abuse was more forceful or longer in duration, the infant may experience seizures, permanent blindness or deafness, mental and developmental delays or retardation, coma, paralysis, and in many cases death. This has recently been called the "Shaken Baby Syndrome" since it most often occurs as a result of violent shaking or shaking of the head. The social impact on children who have been physically abused is perhaps less obvious, yet still substantial. Social consequences include: an inability to form friendships with peers, poor social skills, poor cognitive and language skills, distrust of others, over- compliance with authority figures and a tendency to solve interpersonal problems with aggression. In their adult life, the long-term consequences can impact both their family and their community. There are financial costs to the community and society in general, e.g., funding social welfare programs and services and the foster care system. Studies have shown that physically abused children are at a greater risk for mental illness, homelessness, crime, and unemployment.

Physical Neglect

Physical neglect constitutes the failure to provide a child with basic necessities of life such as food and clothing. This level of neglect is likely to result in the serious impairment of the child's health or development. Neglect can lead to an increased risk of depression in later life as well as dissociative disorders and memory impairments. Changes to the brain caused by neglect have also been linked to panic disorder, posttraumatic stress disorder (PTSD) and attention deficit and hyperactivity disorder

(ADHD) (Child Welfare Information Gateway, 2009). The consequences of physical neglect are long-term and can include: personality disorders, depression, poor academic achievement, which can impact society since it will be more likely that children will have drug abuse problems and educational failure when they grow up if they were victims of child neglect. (Howe, 2011) stated that as a result of the neglect children have poor relationships with their parent or caretakers, usually mother or father and is described by attachment theory. When a child is neglected, she/he doesn't usually have a good relationship or bond with her/his parent. Psychologists would describe this as a poor attachment. Statistics have shown that most often women are reported for neglectful behavior. Neglectful parents interact less with their children, engage in less verbal instruction and play behavior, show less affection and are involved in more negative interactions with their children, like verbal aggression.

Sexual Abuse

Berliner, (2000) and Finkelhor, (1979) defined sexual abuse as involving any sexual activity with a child where consent is not or cannot be given. Studies by David Finkelhor (1979), director of the crimes against children Research Center shows that 1 in 5 girls and 1 in 20 boys is a victim of child sexual abuse. Self-report studies show that 20% of adult females and 5-10% of adult males recall a childhood of sexual assault or sexual abuse incident. During a one-year period in the U.S., 16% of youth ages 14-17 had been sexually victimized. Children are most vulnerable to CSA between the ages of 7 and 13.

A child who is the victim of prolonged sexual abuse usually develops low self-esteem, a feeling of worthlessness and an abnormal or distorted view of sex. The child

may become withdrawn and mistrustful of adults and can become suicidal. It must be noted as well that child abuse is not solely restricted to physical contact but can include noncontact abuse, such as exposure, voyeurism and child pornography.

Coping Styles

Coping is the effort one puts into reducing the negative impact of stress. One's coping style is a combination of attitudes, behaviors, prior experiences, and learning. Avoidance is a coping style often employed (Arata, 1999; Jones & Jones, 2016). According to the *DSM -5*, (2013) avoidance is defined as the act of keeping away from stress related circumstances. It is a tendency to circumvent cues, activities and situations that remind the individual of a stressful event experienced. Active coping takes place when victims of trauma actively try to alleviate their stress and work at controlling their response to things that cause them stress. Another way to look at coping is through Erickson's (1982) model of ego development. Erickson states that individuals progress through eight stages of personality development. At each stage there is developmental crises that results in either an ego strength or its antipathy. Ego strengths are characterized by positive personality characteristic that help the individuals to cope with environmental stressors.

Effect of Abuse and Coping

Research indicates that the environment may have a positive or negative impact on child development. If the environment has a negative effect on development, the resulting difficulties may continue into adulthood. According to Bronfenbrenner's (1994) Ecological system theory, it is not only the immediate, but surrounding environments may play a role in development. The Bronfenbrenner theory is made of five

systems: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem is everything that has direct contact with the child. The microsystem is also seen to be the home base where parents and biology dwell. The mesosystem is where the child's connection with the teacher, parents, and church are starting to combine. The exosystem is the social system in which the child is not directly functioning. However, the exosystem affects the child through the parents and their view of society and culture. The macrosystem is found to be the outermost layer in a child's environment and is comprised of cultural values, laws, and customs. The chronosystem encompasses the dimension of time as it relates to the child's environment. This system can be external like the death of the child's parents or internal such as the child's aging. Each system plays a role in the child's life with or without a trauma happening. Nevertheless, if the child goes through a trauma, these systems may help or further harm the child's development.

Arata (1999) examined coping strategies and post-rape adjustment period. Attribution of blame to rape victims with and without a history of child sexual abuse was explored to test a model for predicting current symptoms based on the abuse history (Arata, 1999). The authors hypothesized that child sexual abuse victims would exhibit greater symptoms and more characterological self-blame and would result in the use of more avoidant coping strategies. The independent variable for this study was child sexual assault and what was being manipulated were attributes and coping adjustments.

This study used 860 female college students from introductory psychology classes as part of the class requirement. The authors only used participants that identified themselves as having experienced forced sexual acts. However, only 14% of the sample

was between the ages of 17 and 47 years, and the other 86% were less than 17 years of age. The participant's relationship status was: single (83, 70 %), 23 (19%) married, and 13 (11%) divorced. The ethnic composition was: ninety-five (80%) white, 21 (18%) African American, and 2 (2%) Latin. Participants completed The Sexual Experiences Survey (Koss & Oros, 1982) that measures adult victimization experiences.

The results showed that victims with a history of sexual abuse had higher levels of trauma and mostly blamed themselves or society for the experience. These results, according to the researcher, showed the importance of "attributions and coping variables" in child rape histories as mediators of post-rape adjustment and were consistent with the hypotheses the researcher laid out (Arata, 1999).

The aim of the study completed by Alvarez, (2011) was to determine the prevalence of child abuse and assess its clinical and prognostic impact on patients with severe mental disorders in a public mental health clinic in a midsize city in Spain. The design of this study was to examine childhood abuse and its effects on individuals and their mental illness in adulthood. The author conducted a cross-sectional study of 102 adult patients from a public mental health care center in the city of Vic in Catalonia, Spain between November 2007 and April 2009. These persons who were invited to participate in the study had mental disorders, according to the (DSM-IV, 1952) criteria for schizophrenia, bipolar disorder, or schizoaffective disorder. Participants were given the *Brief Psychotic Relative Scale* (Overall, 1962) along with the questionnaires *Traumatic Life Events Questionnaire* (Kubany, 2000) and *Distressing Event Questionnaire* (Kubany, 2000)

The *Traumatic Life Events Questionnaire* (Kubany, 2000) was used to assess the history of trauma. There was no direct item concerning psychological abuse or neglect in childhood, and therefore was an open-ended question used to gather information about this abuse subtype.

The results showed lower numbers of physical and sexual abuse than the average reported in an earlier review (Morgan & Fisher, 2007). The data presented showed a prevalence of physical abuse of 22% in males and 18% in females compared with 38% and 35%, respectively, in the study by Morgan et al., and prevalence of sexual abuse of 18.5% and 31.3% compared with 28% and 42%, respectively.

The study conducted by (Alvarez, 2011) found that the more extensive the childhood abuse, the more suicide attempts are likely to happen and this may lead to the individual obtaining a mental disorder. Also, they found that a person who went through childhood abuse may be diagnosed three years earlier with a mental illness. Their findings also showed that females were more likely to suffer abuse than males. However, males were more frequently victims of physical abuse.

The objective of the study conducted by (Morris, Kouros, Fox, Rao, & Garber, 2014) was to research whether inside individual relations between helplessness factors and depressive manifestation were more grounded as an element of the number of depressive scenes that had happened over a lifetime. The authors hypothesized that more severe trauma exposure would predict increases in depressive symptoms and that this relationship would be stronger for individuals with prior major depressive episodes (MDEs).

Participants were 68 young adults who varied with regard to their history of depression; 32 were remitted depressed, and 36 were never depressed. Participants were enlisted essentially from undergrad and graduate projects at an average size college in the southeastern United States and were a piece of a bigger study inspecting reactions to an institutionalized psychosocial stressor. Participants completed the *Beck Depression Inventory-second edition* (BDI-II; Beck, Steer, & Brown, 1996), which is a 21-item, self-report measure of the current level of depressive symptoms. The BDI-II has good reliability and validity (Beck, Steer, Ball, & Ranieri, 1996). In this sample, coefficient alpha for the BDI-II was .85. They also completed *The Childhood Trauma Questionnaire* (CTQ; Bernstein et al., 1994) is a 28-item, self-report measure of the frequency of different types of maltreatment experienced during childhood. Each item is rated on a 5-point scale from never true to very often true. The CTQ has five subscales: emotional abuse, physical abuse, sexual abuse, emotional neglect, and physical neglect. The CTQ has good reliability and validity (Bernstein et al., 1994). In this sample, coefficient alphas for the subscales were .86 for emotional abuse, .76 for physical abuse, .92 for sexual abuse, and 92 for emotional neglect. These four subscales were combined to form a 'weakest link' composite (highest score on any subscale; Abela & Sarin, 2002). The physical neglect subscale was excluded in the analyses because it was unreliable (coefficient alpha = .21) (Morriset al., 20142014).

Participants also completed the *Dysfunctional Attitudes Scale* (DAS; Weissman & Beck, 1978), a 40-item self-report measure of rigid, negative, and perfectionistic attitudes regarding the self, world, and future. Total scores in this measure range from 40 to 280, with higher scores reflecting more dysfunctional attitudes (Morris et al., 20142014).

From the results compiled, 84% (n=100) of the women reported having experienced forced intercourse, whereas 16% (19) reported having engaged in oral or anal sex or having been penetrated by some object due to threats or actual physical force. The majority of women (93%) were victimized by someone they knew, with only 9 women (7%) reporting rape by a stranger. 27% of the women reported having been assaulted in the past year, whereas 24% (28) reported victimization 1 to 2 years ago, 26% (31) were victimized 3 to 5 years ago, and 28% (33) were victimized 5 or more years ago. Forty-two percent (50) of the women reported a history of child sexual abuse, with 58% (69) identified as not having a history of child abuse. Findings highlighted the need for treatment and prevention programs that target stress reactivity and coping strategies early in the course of depression. Limitations state that the study should be replicated with a larger sample. Using a larger sample would show a significant medium-to-large interaction effect size and support the robustness of these results.

In another study concluded by Begemann, Daalman, Heringa, Schutte, & Sommer, (2016), the purpose was to examine how childhood trauma had an effect on the development of psychosis and depressive symptoms. This study focused on how much trauma someone would have to go through before his or her cognitive thinking was compromised. The study claimed that there was noticeable formation of psychosis in some individuals who experienced childhood trauma with the independent variable being childhood trauma and the dependent variable being psychosis.

Participants included two groups: 101 non-clinical individuals with psychotic experiences (auditory verbal hallucinations) and 101 controls.

Childhood Trauma Questionnaire-Short Form (Bernstein, 1998) was used to rate Childhood trauma in the abovementioned groups. All participants were similar with regard to age, gender, handedness and education. To address the effect of childhood trauma, a step-wise regression analysis for those cognitive measures that were significantly lowered in individuals with psychotic experiences in our previous study (Daalman et al, 2011). The results reported more childhood trauma in the group of individuals with non-clinical psychotic symptoms compared to the group with controls.

Diehl et al. (2014) examined age-related changes in coping and defense mechanisms across adulthood and to possible covariates of observed age-related changes in a sample of European American men and women. In this study they discussed that coping and defense mechanisms across childhood are age-related in men versus women and how it changes. From this study we can see additional evidence on how trauma affects men and women differently when it comes to coping styles and how coping varies through different ages.

This study used 392 adults and adolescents of primarily European American descent, 4% had not graduated from high school, 14% had graduated from high school, 31% had attended some college, 18% had received a college degree, 14% pursued education beyond the bachelor level, and 20% had earned a graduate degree.

The authors discussed three major findings in this study. First, despite a good deal of rank-order stability, the coping and defense mechanisms showed systematic age-related change across the adult life span. For the majority of the coping and defense mechanisms, this observed change was nonlinear in nature. Second, of the selected time-varying covariates only ego level was significantly coupled with increases in

intellectualization, and decreases in doubt and displacement. However, changes in coping and defense mechanisms were not associated with changes in intellectual abilities. Third, women and men differed in the use of the coping mechanisms of sublimation and suppression across the adult life span, with women reporting greater use of these mechanisms than men.

The purpose of the study conducted by Arseneault et al, (2011) was to understand how childhood sexual abuse was connected to psychosis and how revictimization experiences, heavy cannabis use, anxiety and depression played a part. Arseneault et al, (2011) assessed the risk of developing psychotic symptoms associated with maltreatment, bullying, and accidents in a nationally representative U.K. cohort of young twins. Participants were members of the Environmental Risk Longitudinal Twin Study (E-Risk), which tracks the development of a nationally representative birth cohort of 2,232 British children. The sample was drawn from a larger birth register of twins born in England and Wales in 1994 and 1995 (9). Briefly, the E-Risk sample was constructed in 1999 and 2000, when 1,116 families with same-sex 5-year-old twins (93% of those eligible) participated in home-visit assessments.

Firstly, all types of trauma were associated with a higher risk for psychotic symptoms at age 12 years, but the effect was especially strong and consistent across time for trauma characterized by intention to harm. Secondly, self-reports of being bullied were more strongly associated with psychotic symptoms than were mother reports of bullying. The risk computed from self-reports of being bullied was nearly twice that computed from maternal reports. Thirdly, the associations with psychotic symptoms were not consistent with accidents, which are characterized by unintentional harm. The

associations were weaker compared with the two other types of trauma, and they were not consistent across time. This study concluded that clinicians who work with children should inquire about traumatic events such as bullying and maltreatment if there are early signs of psychosis noted.

Endler and Parker (1994) conducted four studies. The first study examined psychometric properties and factor structure of the *Coping Inventory for Stressful Situation* (Endler & Parker, 1990,1999). The next study further investigated the construct validity of the CISS. The third study presents knowledge on the construct validity of the CISS by having respondents complete the CISS and various measures of psychopathology. The last study sought to examine the concurrent validity of the CISS by asking two groups of subjects to provide retrospective reports about the coping response they had used when experiencing a specific stressful situation.

Two groups that included college students and adults filled out the *Coping Inventory for Stressful Situations* (Endler &Parker, 1990, 1999). The subject of the first study group consisted of 832 college students of which 397 were male, and 435 were female. The mean age for the males was 20.57 years and for the females 19.36 years. For the second group, there were 483 adults of which 215 were males, and 268 were females. The mean age for the males were 35.59 years and for the females 34.07 years. Both samples of the groups were predominately White. The scale measures three types of coping styles and helps the participant determine his or her preferred coping style of an individual. The scale includes factors dealing with tasks, emotions, avoidance, distraction, and social diversion. The study found that women score higher on the emotion and avoidance scales, while college men scored higher in the task area.

Another part of this study asked the 97 participants to score the *Coping Strategies Indicator* (Amirkhan, 1990), a measure that looks at three basic coping strategies including problem-solving coping, seeking social support and avoidance. The third part of the study asked participants to fill out the *Defense Style Questionnaire* (Andrews G., Pollock C., Stewart G.,1989) that looks at a "cross-section of ego defense styles (Endler & Parker, 1994). The fourth part of the study looked at the concurrent validity of the CISS by asking two groups of participants to look at past reports about coping responses they had when they experienced a specific stressful situation. Overall, the scales find differences between the coping skills of men and women as suggested above. The researchers found their results consistent with other studies using these models and stated that they believe that future research "should be directed at the development of supplementary situational measures of coping" that combines styles and situations of the participants (Endler & Parker, 1994).

Thompson (2000) examined age-cohort variation in childhood trauma. The hypothesis indicates that the children who resided in the Indian Reservations will be more susceptible to having more trauma. The author used the *Canadian National Population Health Survey (NPHS)* (National Population Health Survey, longitudinal health file, 1994), the first wave was a cross-sectional survey that targeted Canadian household members (children and adults included), with the exception of those living on Indian reserves. The sample used was 26,430 households with a response rate of 88%.

The NPHS gathered the information on perceived health, chronic conditions, injuries, depression, smoking, alcohol consumption, physical activity, health professional consultation, and the use of medicines via personal interviews. Only persons aged 20

years and older were selected for further analysis, the final total was 15106 households. Of these households 54.8% were females, and 45% were males. The results reported that prevalence of childhood trauma increased with each successively younger age-cohort (range: 31% to 60%). As the trauma exposure increased, females showed a larger change than males. In the results, a seven-item index consisting of physical abuse, fearful experiences, hospitalization, being sent away from home, and parental disturbance to measure childhood trauma.

Students who reported experiencing childhood emotional abuse tended to report more current distress in part because they used less effective, avoidant strategies to cope with daily stressors. Interventions targeting avoidant coping may be effective for this at-risk group. (APA, 2017)

A study was conducted by Nguyen-Feng et al, (2017) to assess two potential mediators (daily avoidant coping and perceived control) of the relations between past sexual victimization and childhood emotional abuse and current distress. Participants N= 268, were undergraduate students in psychology courses at a large Midwestern university who completed measures of sexual victimization, childhood emotional abuse, neuroticism, and distress at baseline; daily measures of avoidant coping and perceived control over stressors for 14 days (Time 2); and measures of avoidant coping, perceived control, and distress at Time 3. Structural equation modeling (SEM) was used to test the mediation model. The indirect path between childhood emotional abuse and T3 distress through daily avoidant coping was significant and remained significant in an alternate model that controlled for baseline neuroticism. The indirect effect of childhood emotional abuse on T3 distress through perceived control was not significant. Sexual victimization

was not associated with greater use of avoidant coping or perceived control in the SEM models.

Due to these results it was concluded that different forms of trauma exert differential effects in daily life. It may be necessary to teach adaptive coping skills to reduce distress particularly for students with a history of childhood abuse.

In a study conducted by De Prince. A. et al, (2008) focused on examining executive function such as lower school achievements as a result of trauma exposure in children, a sample size of N= 110 from an ethnically diverse community were compared across three exposure groups. These groups include familial trauma, non-familial trauma and no trauma. Of these 110 children (Age mean: 10.39) who guardians reported their child's gender (N=104), 58% were female. Academic performance was measured by a series of tests to assess working memory, behavioral inhibition, processing speed, auditory attention, and interference control.

Results proved that familial trauma was associated with poorer performance relative to non-familial and no trauma exposure. Based on the results gathered it was concluded that trauma does have significant impact on the executive functioning of children placing them at risk for academic, peer and behavioral problems.

Summary

A review of the literature shows that trauma negatively impacts a child's psychological development. Also there are a number of ways that children can cope with the stress of trauma. Trauma is likely to inhibit the psychological development of a child and without early identification and treatment can lead to further mental illness or use of drugs to cope. The general consensus of the studies is that childhood trauma will impact

different individuals differently based on their environment, age at which the trauma occurred other salient characteristics of the abuse, and the age of revelation of abuse.

Different forms of trauma exert differential effects on daily life, and adaptive coping skills may reduce distress in people with a history of childhood abuse. Individuals with better coping tend to have ego strength with positive psychological characteristics that buffer against negative psychological outcomes such as depression and anxiety.

Rationale

The purpose of the current study was to examine the relationship between personality characteristic associated with coping and healthy psychological functioning and depression and anxiety in a group of woman who experienced sexual abuse in childhood.

Hypotheses

It was hypothesized that women with higher levels of healthy psychological traits would have lower levels of depression and anxiety.

Method

Participants

The data was from an archival study by Hive (2009) that looked at childhood sexual abuse, self- schemas, and sexual functioning. A total of 406 adult women with and without a history of childhood sexual abuse initiated the study. A total of 50 cases were deleted for missing data: 30 cases were deleted for missing data on the psychological strength scale and 20 cases were deleted for missing data on the depression and anxiety scale. The final data set included 200 women with a history of childhood sexual abuse and 156 women with no history of CSA. The ethic breakdown of the women with CSA is

as follows: 140 White Non- Hispanic (70%), 22 Hispanic (11%), 11 African American/ Black (5.5%), and 13 Native American (6.5%). The CSA women range in age from18 years to 64 year-olds (*M*= 32.29, *SD*= 10.63). The ethic breakdown of non-CSA women is as followed: 85 White Non-Hispanic (54.5%), 18 Hispanic (11.5%), 17 African American/Black (10.9%), and 4 Native American (2.6%). The non- CSA women range in age from18 years to 69 years-olds (*M*= 31.77, *SD*= 12.35).

Materials

Demographic Questionnaire. This included items such as age, ethnic background, and sexual orientation (see Appendix A).

Childhood Sexual Abuse Assessment. This consisted of a definition of childhood sexual abuse. Participants were asked to answer "Yes" or "No" to the following question; Have you experienced any unwanted sexual contact that was forced or coerce, before the age of 16, by someone who was 5 or more years older? (see Appendix B)

Depression Scale. Participants were asked the following question "How depressed have you felt over the last two weeks?" They answered on a 7- point Likert scale (*0* = not at all and *6* = extremely).

Anxiety Scale. Participants were asked the following question "How anxious, nervous, tense, or worried have you felt over the last 6 months?" They answered on a 7-point Likert scale (*0* = not at all and *6* = extremely).

Sexual Self- Schema Scale (SSSS). The participants answered the SSSS (see Appendix C) by Anderson and Cyranowski (1994). It consists of 50 descriptors rated on a 7- point Likert scale (*0* = not at all descriptive, *6* = very much descriptive). Participants describe themselves on each item (see Appendix). Nineteen items representing positive

psychological characteristics (factors one and two on the sexual self schema Scale) were chosen to make a psychological strength scale (PSS). A total PSS score was calculated by summing the scores of each retained item.

Results

Psychological Strength Scale

Nineteen items of the psychological strengths scale were submitted to an analysis of internal consistency. Cronbach's Alpha was .94.

Correlations

The scores from the depression scale, anxiety scale, and PSS were subjected to a Pearson's correlation. See Table 1 for the CSA women.

Table 1
Correlations of CSA Women

Measures	Depression	Anxiety	PSS
Depression	-		
Anxiety	.793**	-	
PSS	.344**	.415**	-

Note. ** Correlation is significant at the $p < .01$ level, two-tailed. N = 200

Post-Hoc Analyses

Correlations

The scores from the depression scale, anxiety scale, and PSS were subjected to a Pearson's correlation. See Table 2 for the non-CSA women.

Table 2
Correlations of Non- CSA Women

Measures	Depression	Anxiety	PSS
Depression	-		
Anxiety	.713**	-	
PSS	-.057	.043	-

Note. ** Correlation is significant at the $p < .01$ level, two-tailed. N = 156.

T-tests

T- tests were done between CSA and non- CSA women on the dependent variables of depression, anxiety, and psychological strength. See Table 3.

Table 3
Means, Standard Deviation, and t-test for CSA and Non- CSA women

Measures	CSA	Non-CSA	*p*
Depression	4.12 (1.98)	3.13 (1.83)	.04
Anxiety	4.40 (1.91)	3.94 (1.95)	.66
PSS	64.59 (25.89)	75.76 (14.39)	<.001

N- CSA= 200. N- NCSA= 156.

Discussion

The hypotheses were not supported. It was hypothesized that there would be negative correlations between depression and psychological strengths and anxiety and psychological strengths in a group of women who had experienced childhood sexual abuse. In fact, the correlations between depression and anxiety and psychological strength were significantly positive. This is inconsistent with the literature that suggests psychological strength buffers anxiety and depression. There was a positive correlation

between depression and anxiety in the CSA women which is reported in the literature regarding the relationships between depression and anxiety across all population.

A series of post hoc t-test analyses was conducted to try to clarify these results. The same correlational analyses were conducted on a group of women who did not experience childhood sexual abuse and comparisons were made between the CSA and Non-CSA women. The t-test analyses showed that the CSA women did not differ significantly on anxiety from the non-CSA women. However, they did show significantly higher levels of depression and a significantly lower level of psychological strengths than the non-CSA women. There were no significant correlations between psychological strengths and depression and anxiety for the non-CSA women but depression and anxiety were significantly correlated. The results suggest that CSA women have lower levels of psychological strengths than non-CSA women. Furthermore, the maintenance of CSA women psychological strength maybe more psychologically costly.

Limitations

This study aimed to analyze how women with CSA cope with depression and anxiety and if their personality characteristics help provide appropriate coping skills. However, this study may have had limitations that could explain the outcome of the results. The first limitation may be the variability between age at the time of the study and the age at the time of abuse. Some individuals may have had more time to cope with the sexual abuse than others. The second limitation is that the initial study focused on sexual functioning and the sample may not be representative of the average woman with CSA. That is, the relationship between ego strengths and depression and anxiety may be different in a group of CSA women who volunteer for a study on sexual functioning. The

third limitation is that the psychological strength scale was based on the sexual self-schema scale which may have not been the best measure of psychological strength because it was related specifically to sexual self-schema. Future studies should take these limitations into consideration in the investigation of childhood trauma and how it impacts coping in adulthood.

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Appendix A

Demographics Questionnaire

Age: _____

Demographics:

_____ American Indian or Alaska Native

_____ African American/ Black

_____ Asian

_____ Caucasian

_____ Hispanic

_____ Native Hawaiian or other Pacific Islander

_____ Other (please specify): _____

Sexual orientation:

_____ Heterosexual

_____ Lesbian

_____ Bisexual

Appendix B

Childhood Sexual Abuse Assessment

As defined by this study, childhood sexual abuse occurs when a child engages in sexual activity with an adult and the child may or may not fully understand the activity. The adult may coerce the child (e.g., tricking, bribing, threatening, pressuring) into the activity. In activity may or may not include force. Based on this definition, please answer the following question?

Have you experienced any unwanted sexual contact, that was forced or coercive, before the age of 16, by someone who was 5 or more years older?

Yes____ No____ [Yes = sexual abuse]

Appendix C

Sexual Self-Schema Scale

	Not at all descriptive 0	1	2	3	4	5	Very much descriptive 6
generous							
uninhibited							
cautious							
helpful							
loving							
open-minded							
shallow							
timid							
frank							
clean-cut							
stimulating							
unpleasant							
short-tempered							
irresponsible							
direct							
logical							
broad-minded							
kind							
arousable							
self-conscious							
dull							
straightforward							
casual							
disagreeable							
serious							
prudent							
humorous							
sensible							
embarrassed							
outspoken							
level-headed							
responsible							
romantic							
polite							
sympathetic							
conservative							

	Not at all Descriptive	1	2	3	4	5	Very much Descriptive
passionate							
wise							
inexperienced							
stingy							
superficial							
warm							
unromantic							
good-natured							
rude							
revealing							
bossy							
feeling							