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NEGATIVE OUTCOMES ASSOCIATED WITH CHILDHOOD SEXUAL ABUSE

KRISTEN N. SILBERT

59 Pages

The purpose of the study was to examine whether attachment insecurity, global self-esteem, sexual self-esteem, and subjective well-being mediate the relationship between childhood sexual abuse (CSA) and sexual assault during college. The participants included 158 female college students from Illinois State University. Students were granted the opportunity to receive extra credit for participating in the study. Participants completed a demographics questionnaire, the Rosenberg Self-Esteem Scale, the Sexual Self-Esteem Inventory, the Experiences in Close Relationships Questionnaire, the Positive and Negative Affect Schedule, the Satisfaction with Life Scale, the Hot Topics Questionnaire, and the Sexual Experiences Survey. Of the 158 participants, 108 (68.4%) were in the non-CSA group, and 49 (31.0%) were in the CSA group. Nearly half of the participants reported experiencing a sexual assault during college (48.7%). CSA was related to increased vulnerability to experiencing sexual assault in adulthood. CSA was also related to lower levels of global self-esteem and decreased subjective well-being. No difference was found between the non-CSA and CSA group in attachment or sexual self-esteem. Finally, the relationship between CSA and sexual assault was not found to be mediated by attachment, global self-esteem, sexual self-esteem, or subjective well-being.

KEYWORDS: Childhood Sexual Abuse, Outcomes, Sexual Assault

NEGATIVE OUTCOMES ASSOCIATED WITH
CHILDHOOD SEXUAL ABUSE

KRISTEN N. SILBERT

A Thesis Submitted in Partial
Fulfillment of the Requirements
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MASTER OF SCIENCE

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NEGATIVE OUTCOMES ASSOCIATED WITH
CHILDHOOD SEXUAL ABUSE

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CONTENTS

	Page
ACKNOWLEDGMENTS	i
CONTENTS	ii
TABLES	iv
FIGURES	v
CHAPTER I: THE PROBLEM AND ITS BACKGROUND	1
CHAPTER II: LITERATURE REVIEW	3
Theoretical Framework	3
Stigmatization	3
Betrayal	4
Traumatic Sexualization	5
Powerlessness	7
Global, Sexual Self-Esteem, and CSA	8
Global Self-Esteem	8
Sexual Self-Esteem	10
Attachment and CSA	12
Attachment	13
Subjective Well-Being	17
Revictimization	19
The Current Study	22
CHAPTER III: RESEARCH METHODOLOGY	26
Participants	26

Instruments	27
Demographic Survey	27
Childhood Sexual Abuse	27
Sexual Revictimization	28
Attachment	28
Global Self-Esteem	29
Sexual Self-Esteem	29
Subjective Well-Being	30
Procedures	31
Ethical Consideration	31
CHAPTER IV: RESULTS	33
CHAPTER V: DISCUSSION	39
Limitations	43
Future Research	45
Strengths and Contributions	46
Conclusion	46
REFERENCES	48
APPENDIX A: INFORMED CONSENT	55
APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE	57
APPENDIX C: DEBRIEFING STATEMENT	59

TABLES

Table	Page
1. Correlation between mediating variables and outcome variable	36
2. Indirect effects and confidence intervals of mediation analysis	37

FIGURES

Figure	Page
1. Predicted model of the relationship between CSA and sexual assault	23
2. Mediation between CSA and sexual assault	38

CHAPTER I: THE PROBLEM AND ITS BACKGROUND

Childhood sexual abuse (CSA) is not an isolated or infrequent occurrence. The Children's Bureau estimates that one in four girls and one in six boys will experience some form of sexual abuse before reaching the age of 18 (U.S. Department of Health and Human Services, 2010). The World Health Organization (2003) defines CSA as, "the involvement of a child in sexual activity that her or she does not fully comprehend, is unable to give consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society" (p. 75). CSA can be executed by any individual (e.g., adult or child) who is stationed in a position of developmental maturity or understanding of the acts being perpetrated. CSA is associated with a number of negative short-term as well as long-term consequences such as depression, anxiety, anger, decreased self-esteem, dysfunctional sexual behaviors, and later sexual revictimization (Lemieux & Byers, 2002; Rellini & Meston, 2010; Roller et al., 2009; Van Bruggen, 2006).

Recognizing and understanding adult sexual victimization is vital as sexual victimization experiences regularly involve significant, negative psychological and interpersonal distress that is often long lasting in nature (Roodman & Clum, 2001). Sexual victimization, or more commonly referred to as sexual assault, is found to occur at an alarming rate in adulthood. In fact, it is shown that about 20% of women will experience some form of sexual assault in adulthood (U.S. Department of Health and Human Services, 2010). Although the rates for sexual assault are alarming, the rates of sexual revictimization are even more severe. A meta-analysis of 80 studies found that the mean prevalence rate of sexual revictimization across studies was 47.9%, suggesting that almost half of CSA survivors are victimized to further sexual abuse in adulthood (Walker, Freud, Ellis, Fraine, & Wilson, 2017). CSA and sexual revictimization are inherently associated; however, research on what specific factors lead to

revictimization varies. This area of research is important because it can help mental health practitioners, such as counselors or therapists, better understand the effects of CSA on survivors and help with the prevention of sexual victimization later in life. The purpose of the present study was to examine the relationship between the negative outcomes of CSA, such as lower self-esteem and sexual self-esteem, attachment insecurity, decreased subjective well-being, and sexual revictimization in adulthood. This study also examined how negative outcomes of CSA might help to explain increased vulnerability for adult sexual revictimization.

CHAPTER II: LITERATURE REVIEW

Theoretical Framework

Researchers' and professionals' need for a cohesive, descriptive definition of CSA and its outcomes have led to various attempts to conceptualize an all-encompassing model of CSA. Finkelhor and Browne (1985) developed the Traumagenic Dynamic Model to better understand the short-term and long-term outcomes of CSA. The model has four dynamics including (a) stigmatization, (b) betrayal, (c) traumatic sexualization, and (d) powerlessness. Although Finkelhor and Browne focused on how these dynamics transpire during CSA, there is ample evidence that the cognitions and emotions formed after CSA plays a vital role in the child's long-term psychological health. The traumagenic dynamic model has been used extensively in research on CSA.

Stigmatization

The concept of stigmatization refers to the negative meanings that are communicated to the child from others regarding the abuse. These communicated beliefs are then incorporated into the child's sense of self, their schemas, and their attitudes. The perpetrator may blame and degrade the child all while pressuring the child to secrecy. From the pressure for secrecy through explicit threats by the perpetrator, the child may develop feelings of shame and guilt surrounding the sexual abuse (Feiring & Taska, 2005; Finkelhor & Browne, 1985). However, stigmatization is also reinforced by the attitudes conveyed by family members or the community about the abuse (Finkelhor & Browne, 1985). Negative reactions from others about the experiences of CSA can elevate the levels of stigmatization and shame felt by the individual. In a study that reviewed the stories of 19 women who had self-disclosed their experiences of CSA, 36% ($n = 7$) of these women reported it as a negative experience as they indicated feelings of shame and regret from the responses of their romantic partner (MacIntosh et al., 2016).

Stigmatization often manifests itself within an individual as low self-esteem, self-injurious behaviors, and isolation. Stigmatization is brought on as society labels the victim “damaged goods” and directs negative attitudes towards the victim. When children discern negative connotations from others, negative self-views and low self-esteem are reinforced and social connections are significantly threatened (Freyd, 1996). While shame is often a deterrent for self-disclosure, MacIntosh et al.’s (2016) study also found that shame was a motivator for conveying their experiences of CSA to a loved one. Some women felt that their partner had the right to know that they were “damaged goods” which revealed their feelings of low self-esteem as a result of the CSA and society’s victim-blaming stance.

Researchers have found that an abused child’s shame can thwart productive social interaction as it may develop into chronic, painful experiences with the self and others (Feiring et al., 2002; Finklehor & Browne, 1985). This, in turn, can lead to a child’s further engagement in isolating behaviors that are detrimental to their social development. The long-term consequences of psychological distress in adulthood from childhood sexual abuse were found to be mediated by an individual’s feelings of stigmatization, self-blame, and shame (Coffey, Leitenberg, Henning, Turner, & Bennet 1996).

Betrayal

Betrayal refers to a child’s understanding that he or she has been misled or harmed by an individual who they were dependent on and trusted. Erikson (1950) describes trust as one of the first social achievements of an infant. When that trust is broken, the infant or child has subsequent feelings of betrayal. Betrayal often manifests itself in two opposite reactions: one of extreme anger and one of extreme clinginess (Finklehor & Browne, 1985). The child may experience intense rage towards their perpetrator or extreme guilt.

According to the betrayal trauma theory (Freyd, 1996), the relationship between the perpetrator and victim impacts the way a traumatic occurrence is processed and, therefore, remembered. CSA by a caregiving figure threatens the attachment bonds of the victim to the abuser. Therefore, children who are able to block persistent memories associated with the abuse are more capable of preserving their attachment to the caregiver. In this case, the victim may feel a strong desire to regain trust and security with the abuser expressed through extreme clinginess (Finkelhor & Browne, 1985). The concept of “betrayal blindness” (Freyd, 1996), in which the child represses memories of the abuse in order to maintain attachment to the abuser, can be adaptive and maladaptive in certain contexts. Overutilization of betrayal blindness can put a child at a greater risk of vulnerability to revictimization in relationships later in life (Gobin & Freyd, 2014). However, choosing to remember the events of the abuse can be extremely distressing for an individual.

Individuals who experience betrayal from CSA may be more prone to high levels of shame and mistrust (Deblinger et al., 2006). The disillusionment and loss of trust caused by the abuse by an attachment figure may lead a child to develop depression, anxiety, anger, and a deep mistrust of others. The disruption of forming wise decisions about the trustworthiness of others may leave children who experience CSA with an overarching bias that they cannot trust others, hindering future intimate relationships (Gibson & Freyd, 2014).

Traumatic Sexualization

Finkelhor and Browne (1985) defined traumatic sexualization as “the process in which a child’s sexuality is shaped in developmentally inappropriate and interpersonally dysfunctional fashion as a result of sexual abuse” (p. 532). The elicited traumatic sexualization can differ greatly depending on the child’s experience of CSA. The type, severity, whether the abuse

evoked a sexual response in the child, as well as if force was used by the perpetrator all contribute to the process of traumatic sexualization. The perpetrator may reward the child for sexually inappropriate behavior, exchange attention/affection for sex, or fetishize parts of the child's body all which transmit misconceptions about sexual behavior to the child. These misconceptions that the child learns through experiences of CSA can lead them to manipulate others through the use of their sexual behaviors later in life. The experience of CSA can lead to disturbing thoughts and emotions associated with sexual behaviors. Traumatic sexualization can produce psychological difficulties surrounding sexual activities as well as challenges in establishing and maintaining romantic relationships (Finkelhor & Browne, 1985).

Hypersexualized behaviors, as well as inhibited sexual interests, have often been defined as effects of traumatic sexualization. Senn and Carey (2010) found that CSA was uniquely associated with engagement in risky sexual behaviors in adulthood when controlling for other forms of childhood abuse. This finding provides evidence that traumatic sexualization may develop from past experiences of CSA. The severity of CSA was significantly correlated with increased risky sexual behaviors, such as more sexual partners, more unprotected sex, and a higher risk of STIs (Lemieux & Byers, 2008). This means that CSA including penetration, or attempted penetration, may lead to increased traumatic sexualization that develops as a higher likelihood of engaging in sexual risk behaviors (Lemieux & Byers, 2008). CSA was also found to predict low frequency of sexual interaction (Wilson & Widom, 2008), sexual dissatisfaction (Rellini & Meston, 2007), and a range of sexual dysfunctions (e.g., low arousal, unassertiveness, and high sexual anxiety) (Rellini & Meston, 2010) in adulthood. This suggests that this dynamic can take one of two forms - hypersexualized behaviors (i.e., high sexual risk taking) or hyposexualized behaviors (i.e., avoidance of sex).

Powerlessness

The concept of powerlessness refers to the process where the child's resolve, requests, and sense of efficacy are continuously disregarded. The power differential in the relationship between the victim and abuser lies on the side of the abuser as they use threats, deception, coercive tactics, and sometimes fear to exert their power over the child. Force and threats are not exclusive to feelings of powerlessness. Powerlessness can be produced through any situation in which the child feels there is no escape. Furthermore, powerlessness is continuously reinforced as the child's efforts to end the abuse are fruitless. The child feels as though their strengths and resources have been taken away. The child may have nightmares, be victimized in other areas of their life, or experience dissociative symptoms as a result of the feelings of powerlessness (Finkelhor & Browne, 1985). Feelings of powerlessness may cultivate fear, anxiety, and ineffective coping skills within the victim (Canton-Cortes et al., 2012; Finkelhor & Browne, 1985) as they experience the inability to control the abuse. The act of a victim of CSA disclosing the abuse and not being believed can also contribute to feelings of powerlessness.

Feelings of powerlessness have been shown to predict psychological distress (Hazzard, 1993). In particular, Canton-Cortes et al. (2012) found that the dynamic of powerlessness best predicted state anxiety (how a person feels in situations where threat/fear is perceived), trait anxiety (tendency to report and experience negative emotions across many situations), and overall psychological adjustment. In reaction to powerlessness, male victims usually feel the dysfunctional need to compensate for lack of control in past abuse through a pressing need to dominate in later relationships. This is reflected through aggressive behavior and, sometimes, in the victimization of others to regain a sense of power and control (Finkelhor & Browne, 1985).

Global Self-Esteem, Sexual Self-Esteem, and CSA

Finkelhor and Browne's (1985) theoretical conceptualization identifies stigmatization as a possible dynamic resulting from CSA that, specifically, has effects on global self-esteem. Global self-esteem is the value an individual creates about his or her worth (Fennell, 1992). Self-esteem is based on emotions and beliefs of how the individual functions in different areas of life. Self-esteem is most likely first formed in early childhood with a foundation of trust, unconditional love, and security. Research has found that global self-esteem is related to many areas of one's life, such as occupational success, interpersonal relationships, and academic performance (Orth, Robins, & Widman, 2012).

One specific dimension of global self-esteem, sexual self-esteem, may be more relevant to CSA victims than global self-esteem. Sexual self-esteem encompasses cognitions and emotions regarding how an individual interprets herself or himself as a sexual entity (Zeanah & Schwarz, 1996). In relation to Finkelhor and Browne (1985), stigmatization from the incidence of CSA can have deleterious effects on the sexual self-esteem of the victim (Allgeier & Allgeier, 1995; Mayers et al., 2003). Harming an individual's sexual self-esteem has effects that persist beyond childhood and into adolescence and adulthood. Thus, both global self-esteem and the specific domain of sexual self-esteem are elements of an individual who can be affected by CSA. I will review the literature on both concepts next.

Global Self-esteem

Global self-esteem comprises the beliefs a person holds about oneself as an individual and, therefore, significantly impacts the way one thinks, feels, and behaves (Orth, Robins, & Widamen, 2012). Self-esteem can have a cyclical pattern with behaviors and cognitive processes. For example, self-esteem guides behaviors and thought processes an individual has regarding the environment, and the environment's reaction then directs back to influence the individual's self-

esteem. Self-esteem can be applied more narrowly to a certain domain, such as sexual self-esteem (e.g., “I believe I am sexually competent and feel good about that”) or, more generally, global self-esteem (e.g., “I am a bad person”). During childhood, parents have a substantial amount of influence on a child’s self-esteem. As an individual matures, influences outside of the home, such as school, peers, and close friendships, are incorporated into an individual’s self-esteem.

While the building blocks of self-esteem are constructed during childhood, fostering self-esteem is a lifelong process that is reliant upon the experiences encountered by an individual. CSA is an experience that can negatively impact self-esteem in various ways. Past research has consistently shown that CSA is associated with lower self-esteem. In a long-term study, Canton-Cortes, Cortes, and Canton (2012) found that CSA victims generally showed lower levels of self-esteem than non-victims. In addition, a different longitudinal study found that women who experienced CSA prior to age 16 had poorer self-esteem at age 30 than women who were not sexually abused as a child (Fergusson, McLeod, & Horwood, 2013). These both suggest that CSA can have long-term effects that span over the course of adolescence well into adulthood.

Low self-esteem, as a result of CSA, is related to negative mental health outcomes. Low self-esteem may cause an individual to blame the abuse on herself or himself and look inward at his or her own behaviors for an explanation as to why they were sexually abused (Finkelhor & Browne, 1985). Self-blame can heighten the chance that an individual will experience more negative affect (e.g., depression, anxiety, isolation) associated with the sexual abuse. In addition, Bagley and Young (1990) suggest that CSA survivors commonly experience deleterious effects on global self-esteem resulting from the abuse and are at a heightened risk for developing long-term depression and suicidal ideation.

Sexual Self-esteem

Whereas global self-esteem has been examined extensively, there is less research on the specific domain of sexual self-esteem. Sexual self-esteem is defined as “a woman’s affective reactions to her subjective appraisals of her sexual thoughts, feelings, and behaviors” (Zeanah & Schwarz, 1996, p.3). Despite the given definition, sexual self-esteem is a concept that applies to both men and women. This concept can be better understood as the subjective value an individual places on oneself as a sexual being. Zeanah and Schwarz (1996) introduced five affective reactions to sexual self-esteem: Skill and Experience (i.e., one’s ability to please or be pleased by an intimate partner as well as opportunities to participate in sexual activity), Attractiveness (i.e., an individual’s sense of attractiveness), Control (i.e., the ability to govern one’s sexual thoughts, feelings, and interactions), Moral Judgment (i.e., the congruence of one’s sexual control with one’s own values and beliefs), and Adaptiveness (i.e., the compatibility of one’s sexual experiences and behaviors with other personal goals). Zeanah and Schwarz (1996) suggested that each of the five affective reactions not only contribute to overall sexual self-esteem but global self-esteem as well.

Low sexual self-esteem can result in a variety of problematic symptoms, including health problems, depression, anxiety, shame, suicidal ideation, isolation, diminished sexual interest/activity, and other sexual dysfunction (Barnum & Perrone-McGovern, 2017; Kelly & Erickson, 2007; Krahe & Berger, 2016; Mayers et al., 2003; Van Bruggen et al., 2006). In addition, past studies examining sexual self-esteem have suggested that lower sexual self-esteem may be negatively related to sexual satisfaction (Menard & Offman, 2009). On the other hand, high levels of sexual self-esteem are associated with healthier sexual relationships (Kelly & Erickson, 2007), better-developed sexual communication skills (Allgeier & Allegeier, 1995;

Oattes & Offman, 2007), and healthier sexual practices (Maas & Lefkowitz, 2015). Higher sexual self-esteem is manifested as feeling sexually competent, attractive, and accepted by romantic partners.

The potential for damage to sexual self-esteem can come from many different sources. Sexual self-esteem can be damaged by others' actions through demeaning or insulting language directed at an individual's sexual behavior or sexuality (Mayers et al., 2003). Jargon such as "slut," "whore," and "fag" have the capability to extensively harm the development of one's sexual self-esteem. This is especially relevant in children who have not fully formed their identity as a sexual being. Events that cause emotional disturbances can unconsciously distort sexual self-esteem, which may reinforce or add to feelings of guilt, degradation, self-disgust, and humiliation (Mayers et al., 2003). These negative outcomes on one's sexual self-esteem may then impact an individual's future sexual behaviors and attitudes. These findings suggest that sexual self-esteem may follow the same cyclical pattern as global self-esteem (e.g., sexual self-esteem influences outcomes of guilt, self-disgust, and humiliation, which then impacts an individual's sexual self-esteem).

Given that CSA has links to global self-esteem, researchers have begun to study, more specifically, the effects of CSA on sexual self-esteem. Women who are victims of CSA may develop uneasy feelings associated with the role of sex in their interpersonal relationships (e.g., misconceptions about the role of sex, ambivalence about sexual norms) and negative affect concerning their sexuality (Van Bruggen et al., 2006). More specifically, CSA may become a defining component to a person's sexual self-esteem and may contribute to future experiences of sexual victimization. Furthermore, the use of sexual threats and coercion during CSA may increase even further the likelihood that a victim's sexual self-esteem will be negatively

impacted. According to Mayers et al. (2003), sexual victimization can lead to a “damaged” image of an individual’s sexuality causing severe difficulties and mental health problems. Kelly and Erickson’s (2007) study of undergraduate students found that traumatic childhood experiences were associated with low sexual self-esteem and the absence of positive, secure sexual relationships. A similar study of college women found that women with a history of CSA had lower sexual self-esteem, had inferior sexual adjustment, and were two times more likely to have been sexually revictimized after the age of 14 years than college women without a history of CSA (Van Bruggen et al., 2006). Specifically, they found that CSA was related to sexual self-esteem on two of the affective reactions: Moral Judgment and Control. In a follow-up study, Kelly and Gidycz (2015) provided additional evidence that CSA severity was associated with the sexual self-esteem affective reaction of Control. This finding implies that the more severe the CSA (e.g., penetrative sexual abuse, abuse over a longer period of time, or abuse by a parental figure), the more problems a survivor had with managing his or her own sexual thoughts, feelings, and interactions.

Attachment and CSA

Finkelhor and Browne’s (1985) theoretical framework identified betrayal as a possible dynamic that results from childhood sexual abuse. Betrayal can be manifested in interpersonal problems, specifically attachment. The attachment bond between infant and caregiver is an imperative development during the infant’s primary years as it facilitates caregiving and survival for the infant. Erikson (1968) proposed a theory of eight psychosocial stages that ranged from infancy into adulthood. In Erikson’s first stage of development, an infant experiences the psychosocial crisis of trust vs. mistrust, which could have a positive outcome (trust) or negative outcome (mistrust). During this stage, the infant has uncertainty about the world and its events

and requires his or her primary caregiver to provide stability. Infants who learn that their caregivers are consistent and stable in their responses form a sense of trust. Infants who learn that their caregivers are not consistent or stable will form feelings of mistrust or betrayal. As indicated above, CSA is theoretically posited to result in feelings of betrayal or feelings of mistrust that influence the development of attachment.

Attachment

Attachment refers to the deep emotional bond that connects a child to a caregiving figure and the caregiving figure to the child (Bowlby, 1969). Attachment is a lifelong process that has its origins in the beginning of life, as an infant, and guides interactions with others later in life (Karakurt & Silver, 2014). Bowlby (1969) and Ainsworth (1989) were the pioneers of the work on attachment theory. Bowlby's (1969) theory of attachment suggests that children come into this world with a predisposition to form an attachment bond with others to help them survive. He postulated that infants form internal working models, which are defined as cognitive frameworks that are made up of mental representations of the world, self, and others. These internal working models are influenced by memories and expectations that guide an individual's interactions with others. In addition, Bowlby (1969) believed that the attachment relationship between infant and caregiver serves as a model for future relationships to follow through the internal working models an infant has formed.

Ainsworth's (1989) famous research provided an explanation of individual differences in attachment that included four infant attachment styles. These different attachment styles (secure, avoidant, anxious-ambivalent, and disorganized) are a framework that remain relevant throughout a child's lifespan (Alexander, 1992) and are reflected in later adult attachment behaviors. According to Ainsworth (1989), securely attached infants reflect internal working

models where they expect that their caregiver will be sensitive to their needs. Caregivers of securely attached infants are more likely to be emotionally available, perceptive, and responsive to the infant's needs. Avoidant patterns of attachment often come about from a caregiver being insensitive and rejecting when the child is experiencing emotional distress. Infants will then avoid seeking comfort from the caregiver and learn to distance themselves from situations that are emotionally overwhelming in order to cope with his or her distress independently. Infants who display anxious attachment have caregivers who are unpredictable and inconsistent in their responses, which leads the infant to learn that even if his or her caregiver is physically present, he or she will not be able to soothe them. Infants with anxious attachment use overactivation of their attachment system in order to get their needs met (e.g., clinginess, extreme crying, anger). Disorganized attachment refers to children who experience caregivers who are insensitive, neglectful, or abusive (Lyons-Ruth, Bronfman, & Parsons, 1999). Infants who have disorganized attachment styles display inconsistent patterns of attachment; at times the infant can be clingy, and at other times the infant may be extremely reluctant to approach the caregiver. Infants with this attachment style have internal working models that are not functional since their source of soothing is also the source of danger. The infants' disorganized behavior comes about from a constant situation of fear with no solution.

Attachment styles that are formed in infancy provide the structure on which relationships are formed later in life (Bowlby, 1969). Bartholomew and Horowitz (1991) developed an encompassing, four-category model of adult attachment that closely resembles the attachment styles found in infancy. These four adult attachment categories (secure, dismissive, preoccupied, and fearful) are based on how positively or negatively an individual views oneself and others. Individuals with secure attachment have an internal working model in which they hold positive

views of both the self and of others. These individuals find ease and comfort with intimacy and autonomy as they were likely to have a secure attachment with their caregiver in infancy. Each of the insecure attachment styles (dismissive, preoccupied, and fearful) is defined by its own arrangement of interpersonal problems. Those with a dismissive attachment have a positive view of the self and a negative view of others. These individuals display independence, self-sufficiency, and a tendency to avoid close relationships. This is similar to avoidant attachment in infancy as it has been engrained into their character that to get their needs met they must do everything by themselves. Preoccupied attachment is characterized by negative views of the self and positive views of others. Individuals with this attachment style feel anxious in their relationships and tend to spend a significant amount of time and energy in attempt to maintain relationships. This relates back to anxious attachment in infancy as the individual worries that their needs will not be consistently met. Lastly, fearful attachment is described as individuals who have a negative view of the self and a negative view of others. They may have extreme ambivalence about intimate relationship marked by their trepidation of their own vulnerability and anticipation of harm from others. Fearful attachment most closely resembles disorganized attachment in childhood, which research has also found to be associated with abuse (Lyons-Ruth, Bronfman, & Parsons, 1999). Not surprisingly, victims of CSA have been found to have higher levels of fearful attachment behavior than non-victims (Asplemeier, Elliott, & Smith, 2007).

Research suggests that CSA and attachment are connected (Asplemeier, Elliott, & Smith, 2007). Typically, early relationships serve as a shelter as they provide a source of protection for the child. However, relationships involving sexual abuse are the cause of pain and fear for the victim. Relationships involving CSA may create negative internalized interpersonal structures, such as fearful or avoidant attachment, in children and adults (Herman, 1992; Lahav & Elklit,

2016). Studies have found that survivors of CSA show higher levels of attachment insecurities compared to non-abused adults (Alexander, 2009; Rumstein-McKean & Hunsley, 2001). Specifically, CSA victims are more likely to hold disorganized or fearful attachment styles than non-CSA individuals (Alexander, 1993; Elkit, 2009). This reveals the underlying anxiety and avoidant behaviors that CSA victims have a tendency to display. Aspelmeier, Elliot, and Smith (2007) studied attachment in college women with a history of CSA and found that those with a history of CSA reported higher levels of dismissive, preoccupied, and fearful attachment styles when compared to those with no history of CSA. Those with no history of CSA reported higher levels of secure attachment than victims of CSA.

CSA is a traumatic event that usually occurs during vulnerable developmental periods. Therefore, the effects of CSA on attachment insecurities are extremely harmful when the perpetrator is an attachment figure. CSA can create problems in later intimate relationships by generating attachment insecurities where the victim draws upon maladaptive internal working models for future relationships (Murphy et al., 2016). Thus, adult internal working models, or attachment styles, can include expecting harm from others and feelings of anxiety in close relationships. Furthermore, insecure attachment can be problematic in adult relationships because it may cultivate feelings of hostility, antisocial behaviors, impulsivity, helplessness, and difficulties maintaining relationships (Liang, Williams, & Siegel, 2006). Often, behaviors of anger and hostility are used as a strategy to deal with the feelings of pain and suffering caused by childhood traumas, such as CSA (Bailey et al., 2007). In a sample of 80 female adolescent ages 14 to 16, Sharpio and Levendosky (1999) found that attachment mediated the relationship between CSA and psychological distress. In fact, research suggests that CSA and

psychopathological problems, such as PTSD, may be mediated by the level of attachment insecurity (Dimitrova et al., 2010).

Subjective Well-Being

Subjective well-being can be defined as “a person’s cognitive and affective evaluations of his or her life” (Diener, Lucas, & Oishi, 2002, p. 63). The cognitive dimension refers to what one thinks about his or her life satisfaction globally (e.g., overarching, life as a whole) and in domain-specific areas (e.g., work, relationships). The affective dimension refers to emotions, feelings, and moods. Affect is regarded as positive when the emotions, feelings, and moods experienced are pleasant (e.g., feelings of joy, happiness, warmth). Affect is regarded as negative when the emotions, feelings, and moods felt are unpleasant (e.g., anger, sadness, guilt, shame). Correspondingly, Diener, Lucas, and Oishi (2002) state that subjective well-being consists of three distinct but related dimensions: life satisfaction (e.g., tendency to evaluate one’s life as happy), positive affect (e.g., enthusiasm, pleasure), and the absence of negative affect (e.g., sadness, nervousness). Thus, the presence of positive affect does not necessarily mean the absence of negative emotion and vice versa. Individuals who often have high levels of life satisfaction, experience greater positive affect, and experience less negative affect would be considered to have higher levels of subjective well-being in comparison to individuals who often have low levels of life satisfaction, experience low positive affect, and experience more negative affect.

Subjective well-being is a concept that falls within the hedonic perspective, in which well-being consists of happiness or pleasure (Lent, 2004). The hedonic view focuses mainly on the experience of pleasant feelings as well as a balance of positive and negative affect (Ryan & Deci, 2001). This is in contrast to the eudaimonic perspective in which well-being is

characterized by the way in which one lives in accordance with one's "daimon" or true self, rather than just merely happiness (Watermen, 1993). This view places emphasis on the extent to which an individual fully integrates one's "true self" into his or her life. Subjective well-being is easily confused with quality of life, and, therefore, the two terms need to be distinguished from each other. Whereas subjective well-being refers to the evaluations one makes of his or her life, it is just one of several measurements of quality of life. The term quality of life is used as a "conceptual umbrella" for various constructs that measure physical, social, or emotional functioning (Gladis, Gosch, Dishuk, & Crit-Christoph, 1999).

To better understand subjective well-being, Lent (2004) created two cohesive models of how cognitive, behavioral, social, and personality factors foster well-being. In Lent's (2004) normative model, subjective well-being is described as utilizing "normative life conditions." In this model, subjective well-being is postulated as being manipulated by affective dispositions (e.g., positive and negative affect) and personality characteristics within the individual that progress him or her towards a satisfying life. While the normative model portrays well-being in the normal cycle of day-to-day functioning, Lent's (2004) model of restorative well-being encapsulates the way in which individuals recover their subjective well-being following a traumatic life event. The model of restorative well-being is considered an extension of the normative model as usual subjective well-being processes are disrupted by traumatic life events, such as CSA. In this model, when an individual appraises an event to be traumatic and he or she deems that they do not have the necessary coping skills to manage the traumatic incidence, the incident is more likely to have an adverse impact on one's subjective well-being and symptomatically as depression and anxiety (Lent, 2004). This process relates back the normative model as particular personality traits, positive affect, and negative affect all color the way in

which a person initially appraises the traumatic event. Therefore, individuals who experience trauma are more likely to have difficulties maintaining higher levels of subjective well-being than those who have not experienced trauma. These changes can be minor, such as brief adaptations to one's mood, or they can be major subsequent changes to one's outlook on life (Barnum & Perrone-McGovern, 2017).

CSA is a traumatic event that can have substantial negative changes on an individual's subjective well-being. Numerous studies have found that individuals who report CSA are likely to have symptoms of depression, anxiety, and PTSD (Lemieux & Byers, 2002; Rellini & Meston, 2010; Roller et al., 2009; Van Bruggen, 2006). All of these symptoms include increased negative affect as well as a decrease of positive affect. In addition, Barnum and Perrone-McGovern (2017) found that individuals who reported CSA specifically revealed lower levels of subjective well-being than individuals who did not experience CSA. They theorized that the level of subjective well-being an individual has following CSA may influence the way in which an individual will perceive him or herself in their world, thus leaving the individual vulnerable to sexual assault in adulthood. In addition, another study suggests that CSA is associated with negative perceptions of life in both men and women (Becker-Lausen, Sanders, & Chinsky, 1995).

Revictimization

Sexual revictimization is typically referred to as repeated sexual assault across different developmental periods (e.g., as a child and as an adult) (Davis, Combs-Lane, & Jackson, 2002). Alarming, research strongly suggests that individuals who experience CSA are more likely to experience sexual revictimization than those who were not sexually victimized in childhood (Messman & Long, 1996; Messman-Moore & Long, 2003; Reese-Weber & Smith, 2011). In

fact, some researchers have contended that CSA is among the strongest predictors of revictimization in adulthood, especially among women (Barnes et al., 2009; Casey & Nurius, 2005). However, very little is known about the pathways from CSA to sexual revictimization risk in adulthood, despite the common occurrence of sexual revictimization (Diagle, Fisher, & Cullen, 2008; Ullman & Vasquez, 2015). More advanced research has supported the idea that there are various pathways with multiple mediating factors that link experiences of CSA to adulthood sexual revictimization (Classen, Palesh, & Aggarwal, 2005; Simmel & Postmus, 2012).

Although Finkelhor and Browne's (1985) traumagenic dynamics is not directly a theory of revictimization, the model can still provide a useful framework for understanding the relationship between CSA and later sexual revictimization. As described earlier, this model reflects the negative outcomes that follow CSA (i.e., stigmatization, betrayal, traumatic sexualization, and powerlessness). Children who experience stigmatization from the abuse often develop low self-esteem and increased feelings of shame and guilt (Finkelhor & Browne, 1985). Low self-esteem and shame may result in a negative self-image within the child and, subsequently, position the child at an elevated risk for revictimization later in life (Jehu & Gazan, 1983). As noted above, betrayal affects attachment bonds as well as trust. Therefore, victims of CSA may have a harder time determining whether individuals are trustworthy and are more vulnerable to sexual revictimization than those who have not experienced CSA (Reese-Weber & Smith, 2011). Traumatic sexualization, as a result of CSA, may lead to the development of inappropriate and dysfunctional sexual attitudes and feelings (Finkelhor & Browne, 1985). Through the exchange of sexual behavior for attention and affection, the abuser teaches the child to utilize sexual behaviors to manipulate others. Consequently, traumatic

sexualization creates misconceptions in relation to sexual behaviors that may extend into adulthood and prompt adulthood revictimization (Messman & Long, 1996). Lastly, powerlessness is another effect of CSA that can negatively impact sexual revictimization. Learned helplessness is a term that is equivalent with the concept of powerlessness, despite the different labels (Reese-Weber & Smith, 2011). Learned helplessness (Seligman, 1975) is a mental state in which an individual deems that he or she is unable to control any significant events in his/her life and encompasses situations that have the potential to be controlled by the individual. CSA is an event in which victims experience uncontrollable abuse; CSA may therefore teach victims that they are helpless and, therefore, powerless. Thus, victims who have learned that they have no power to stop abuse are at risk for revictimization when confronting abusive situations in the future.

There has been a lot of research conducted that suggests that CSA, sexual assault, and sexual violence impact a survivor's subjective well-being (Poutiainen & Holma, 2013). Although subjective well-being has been widely researched in different contexts, it has not been researched in terms of a connection between CSA and sexual revictimization. It may be that subjective well-being is a mediator in the relationship between CSA and later sexual revictimization. Research has suggested that positive events seem to increase an individual's subjective well-being, while negative events have a decreasing effect (Diener, Lucas, & Oishi, 2002; Poutiainen & Holma, 2013). In addition, one's perceived ability to control life events is related to the overall impact an event has on an individual's subjective well-being. Therefore, when CSA does not produce feelings of powerlessness in an individual, it may be that one's subjective well-being is less impacted. This relatively static belief that one has the ability to control his or her life may influence an individual's subjective well-being in a positive light and, thus, decrease

vulnerability to future sexual revictimization. If an individual believes that he or she can maintain one's life in a positive manner and have high satisfaction with life, even with past sexual abuse, it suggests that subjective well-being may mediate the relationship between CSA and vulnerability to later sexual revictimization.

The Current Study

There is a significant amount of research on CSA and sexual revictimization. Research has found that CSA is a significant issue among women with one in four women being the victim of sexual abuse during childhood (Finkelhor & Browne, 1985). Therefore, the present study used a population sample of only college women. In addition, women with a history of CSA are twice as likely to experience sexual revictimization in adulthood than those without a history of CSA (Messman-Moore & Brown, 2004; Van Bruggen et al., 2006). Using the framework developed by Finkelhor and Browne (1985) as well as the concept of subjective well-being, the present study examined the mediating effect of self-esteem, sexual self-esteem, attachment, and subjective well-being of CSA survivors in regards to sexual revictimization (see Figure 1).



Figure 1. Predicted model of relationship between CSA, attachment insecurity, global self-esteem, sexual self-esteem, subjective well-being (i.e., positive and negative affect, satisfaction with life), and sexual assault.

This study investigated the relationship between self-esteem and sexual revictimization of those who have experienced CSA. Thus far, research has shown that experiences of CSA lead to lower global self-esteem (Canton-Cortes, Cortes, & Canton, 2012; Fergusson, McLeod, & Horwood, 2013; Finkelhor & Browne, 1985). However, some have argued that global self-esteem may be too broad of a construct (Oattes & Offman, 2007), and the specific aspect of sexual self-esteem may be a more concise mediator between CSA and revictimization. Sharpio and Schwartz (1996) found that women who have experienced sexual abuse had significantly lower sexual self-esteem in the areas of Moral Judgment, Adaptiveness, and Control than women

who had never experienced sexual abuse. However, it is unclear whether reduced sexual self-esteem plays a role in sexual revictimization. This study aimed to examine this mediational relationship.

The study also investigated the relationship between CSA, attachment, and sexual revictimization. Research has shown that CSA experiences contribute to insecure attachment styles (Alexander, 2009) in childhood, which affect later adult internal working models of relationships. Research is inconclusive on how attachment is related to sexual revictimization in adulthood. Brenner and Ben-Amitay (2015) found that those with higher attachment anxiety were more likely to be sexually revictimized than those with secure attachment. However, these researchers also found that attachment avoidance was not found to be associated with adult sexual revictimization. Reese-Weber and Smith (2011) found that CSA victims did not differ from non-CSA individuals on levels of attachment anxiety and attachment avoidance. However, in the same study, attachment style was found to be a significant predictor of sexual assault among college students (revictimization among the college students with a history of CSA). This present study examined whether attachment mediates the relationship between CSA and sexual revictimization later in adulthood. However, theory suggests that attachment avoidance should increase an individual's vulnerability to revictimization and, therefore, will be examined in this study.

Finally, the present study examined the mediating effects of subjective well-being on the relationships between CSA and sexual revictimization. Whereas various research has suggested that CSA impacts subjective well-being negatively, there has not been much research on whether subjective well-being affects sexual revictimization. Based on the previous findings on the

relationship between CSA, attachment, self-esteem, sexual self-esteem, and subjective well-being; the following hypotheses were proposed.

1. Women who experienced CSA would be more likely to be sexual revictimized in adulthood than women who did not experience CSA.
2. Participants who have experienced CSA would report higher attachment anxiety and higher attachment avoidance than participants that have not experienced CSA.
3. Participants who have experienced CSA would report lower global self-esteem than participants that have not experienced CSA.
4. Participants who have experienced CSA would report lower sexual self-esteem than participants which have not experienced CSA
5. Participants who have experienced CSA would report lower subjective well-being than participants that have not experienced CSA.
6. Global self-esteem, sexual self-esteem, attachment avoidance, attachment anxiety, and subjective well-being would mediate the relationship between CSA and sexual revictimization. More specifically, global self-esteem, sexual self-esteem, and subjective well-being would have a negative b path, while attachment avoidance and attachment anxiety would have a positive b path.

CHAPTER III: RESEARCH METHODOLOGY

Participants

The study included 158 female undergraduate students from Illinois State University. Women ranged in age from 18 to 25 with the mean age being 19.46 ($SD = 1.46$). Of the 158 female undergraduate participants, 108 (68.4%) were in the non-CSA group, 49 (31.0%) were in the CSA group, and 1 (0.2%) participant did not complete the study. Of all the participants, 81 (51.3%) were in the non-sexually assaulted group, and 77 (48.7%) were in the sexually assaulted group. Based on self-reports by the participants, 99 (62.7%) identified as white, 28 (17.7%) identified as Black/African-American, 19 (12.0%) identified as Hispanic/Latino, 4 (2.5%) identified as Asian/Asian-American, and 8 (5.1%) identified as other ethnicities. Most of the participants identified as straight (94.5%), and the remaining identified as lesbian (0.6%) or bisexual (4.4%). Almost all of the participants lived in the residence halls (56.3%) or in an apartment with friends (38.0%), some lived in apartments alone (2.5%), some lived with their partner (2.5%), and some had other living situations (0.6%). Of the participants, 53.8% had biological parents that were still married, 25.3% had biological parents that were divorced, 20.9% reported having a single parent or other family status.

Instruments

Demographics questionnaire

Participants completed a demographics questionnaire which includes information about age, gender, sexual orientation, ethnic background, current living situation (with parents, alone, or living with others), family composition, and parental education.

Childhood Sexual Abuse

The Hot Topics Questionnaire, originally developed by Reese-Weber and Smith (2011), was modified to 15 items that encompass yes-or-no questions regarding mental health, substance abuse, and experiences of childhood sexual abuse. This questionnaire includes 5 items focused on assessing nonconsensual sexual experiences. The critical items assessing CSA include: (a) “Before the age of 18, someone had sexually touched me in ways that made me feel uncomfortable”; (b) “Before the age of 16, I had a sexual experience with an individual five or more years older than myself (any sexual activity involving physical contact)”; (c) “Before the age of 18, another person coerced me to engage in sexual activity (intercourse, oral sex, anal sex, petting/fondling)”; (d) “Before the age of 18, I had engaged in sexual activity (intercourse, oral sex, anal sex, petting/fondling) when I didn’t want to because someone threatened to use physical force”; and (e) “Before age 18, I had been sexually assaulted”. Answering no to all of the 5 items led to assignment in the non-CSA group. Answering yes to any of the 5 items led to assignment in the CSA group.

Participants who answered ‘yes’ to any of these 5 items completed a modified version of the Childhood Sexual Abuse Questionnaire (CSAQ; Finkelhor, 1979) that examines the individual’s age when abused, the age of the abuser, the relationship to the abuser, what happened, and the participant’s overall distress about the experience. This is important

descriptive information and was used to verify abuse status. The original CSAQ consists of 10 items asking about childhood sexual abuse prior to age 16. This modified version consists of 12 questions about childhood sexual abuse prior to age 18. Question types are varied but include: fill-in-the-blank, 10-point Likert scale, yes/no, and checking boxes. Risin and Kross (1988) indicated that the CSAQ has good concurrent validity.

Sexual Revictimization

The Sexual Experiences Survey assesses sexual victimization after the age of 18 years old. The questionnaire includes 12 yes-or-no items, with the last item asking the individual to whom, if anyone, they disclosed their sexual victimization. This questionnaire was used to determine individuals who have been sexually revictimized after the age of 18 and includes items such as, “Have you ever had sexual intercourse with a man or women when you really didn’t want to because he/she used physical force (twisting your arm, holding you down, etc.)?” and “Have you ever been raped?” Answering yes to any of the questions led to assignment in the sexually assaulted group, and answering no to all of the questions led to assignment in the non-sexually assaulted group.

Attachment

The Experiences in Close Relationships-Revised (ECR-R; Fraley, Waller, & Brennan, 2000) is a questionnaire which assesses individual differences in adult attachment with respect to two subscales: adult attachment-related anxiety and adult attachment-related avoidance. Representative items for the anxiety and avoidances subscales include “I often worry that my partner doesn’t really love me” and “I find it difficult to allow myself to depend on romantic partners,” respectively. Respondents were asked to rate each of the 36 items on a 7-point Likert scale from (1) *strongly disagree* to (7) *strongly agree*. Respondents were asked to indicate how

they *generally* feel in relationships, as opposed to how they feel in a specific, current relationship. Average scores are calculated for both the anxiety and avoidance subscales. Sibley and Liu (2004) found good internal consistency for attachment avoidance (.91) and for attachment anxiety (.93). In the present study, the alpha coefficients were .92 for attachment avoidance and .92 for attachment anxiety.

Global Self-Esteem

Participants completed the Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) to assess individual levels of global self-esteem. The RSE is comprised of 10 items rated on a 4-point Likert scale from (1) *Strongly Disagree* to (4) *Strongly Agree*. Silber and Tippett (1965) found that, over a 2-week period, test-retest was .85, and correlations with related measures ranges from .56-.83. The current study found good internal consistency (Cronbach's alpha = .90).

Sexual Self-Esteem

The sexual self-esteem scale (short form) is a 35-item scale used to measure an individual's self-appraisals of sexual thoughts, feelings, and behaviors (Zeanah & Schwarz, 1996). Each of the 35 items is rated on a 6-point Likert scale from (1) *Strongly Disagree* to (6) *Strongly Agree*. Sexual self-esteem is measured through five affective reactions, or subscales: skill and experience (e.g., I feel that 'sexual techniques' come easily to me), attractiveness (e.g., I am pleased with my physical appearance), control (e.g., I feel I can usually judge how my partner will regard my wishes about how far to get sexually), moral judgment (e.g., my sexual behaviors are in line with my moral values), and adaptiveness (e.g., I like what I have learned about myself from my sexual experiences). Internal consistency has been good (.92) for the overall sexual self-esteem score (Zeanah & Schwarz, 1996). In the present study, alpha levels

also indicated good internal consistency for each of the subscales, skill/experience (.86), attractiveness (.90), control (.78), adaptiveness (.84), and moral judgment (.78).

Subjective Well-Being

Subjective well-being was assessed with two measures. First, the Satisfaction with Life Scale (SWLS; Diener et al., 1985) is a short, 5-item instrument used to measure cognitive judgments about satisfaction with life. Each of the 5 items is rated on a 7-point Likert-type scale from (1) *Strongly Disagree* to (7) *Strongly Agree*. These items include items such as, “In most ways my life is close to my ideal” and “I am satisfied with my life.” Diener, Emmons, Larsen, and Griffin (1985) found good test-retest reliability (.82). The current study found good internal consistency (Cronbach’s alpha = .90).

Second, the Positive and Negative Affect Schedule (PANAS; Watson, Clark, & Tellegen, 1988) is a 20-item self-report measure of positive affect and negative affect domains of subjective well-being. The scale measures positive and negative affect separately, each consisting of 10 items. Items are scored on a 5-point Likert-type scale ranging from (1) *not at all* to (5) *extremely*. Items such as “enthusiastic” and “proud” measure positive affect, whereas items such as “guilty” and “irritable” measure negative affect. Watson, Clark, and Tellegen (1988) found good internal consistency for positive affect (Cronbach’s alpha = .89) and negative affect (Cronbach’s alpha = .85). Similarly, the current study found good internal consistency for positive affect (Cronbach’s alpha = .85) and negative affect (Cronbach’s alpha = .88).

Procedure

Participants were recruited using the psychology department online SONA system. Participants assembled in small groups inside various classrooms located throughout the Illinois State University campus. Each participant signed an informed consent document and was given an additional copy to take home with them. After signing the researcher's copy of informed consent, participants were given the survey packet, which included the demographic questionnaire, Hot Topics Questionnaire, Childhood Sexual Abuse Questionnaire, Sexual Experiences Survey, Experiences in Close Relationship-Revised questionnaire, Rosenberg Self-Esteem Scale, Sexual Self-Esteem Scale – Short Form, Positive and Negative Affect Schedule, and Satisfaction with Life Scale. The survey was completed by pen and paper. Upon completion of the survey packet, participants were asked to place their survey packet in a manila envelope and to place the envelope in a box near the front of the room. After dropping the envelope in the box, participants received both a verbal and written debriefing statement containing information about how to contact the researchers and local sexual abuse resources. This study compensated the participants with one and a half points of extra credit for a psychology course.

Ethical Considerations

Participants were seated with at least one seat in between them to increase confidentiality of answers. Once the survey was completed, the participants placed the survey into manila envelopes to ensure that the responses remain anonymous from other participants and the researchers. In addition, all research assistants were trained to observe participants for any signs of visible distress throughout the completion of the study. When participants turned in their sealed survey, they were asked if the study caused them any emotional harm. In the event that a participant did become emotionally distressed, research assistants reminded him or her that they

could withdraw from the study at any time, asked if the participant would like to call someone to pick them up, and/or asked if the participant would like to be walked over to the student counseling center. However, none of the participants become upset or expressed concern over the study. All participants received a debriefing statement that contained a list of contact information (i.e., phone number) for local counseling resources for them to contact if needed.

CHAPTER IV: RESULTS

The first hypothesis, women who experienced CSA will be more likely to be sexual revictimized in adulthood than women who did not experience CSA, was examined using a chi-square test. Of the 108 participants in the non-CSA group, 41 (38.0%) were in the sexually assaulted group, and 36 (73.5%) of the 49 participants in the CSA group were in the sexually assaulted group. These frequencies did differ significantly from each other, $\chi^2(1, N = 157) = 17.00, p > .001$. Those in the CSA group were almost twice as likely to report a later sexual assault than those in the non-CSA group. Thus, the hypothesis was supported.

The next four hypotheses stated that individuals who experienced CSA would report (a) higher attachment anxiety and avoidance, (b) lower self-esteem, (c) lower sexual self-esteem, and (d) lower subjective well-being. Multiple independent samples *t*-tests were conducted to analyze whether there was a difference between the CSA and non-CSA groups on mean levels of attachment, self-esteem, sexual self-esteem, and subjective well-being. Regarding Hypothesis 2, participants who experienced CSA ($M = 3.13, SD = 1.18$) did not report significantly higher levels of attachment anxiety than those in the non-CSA group ($M = 2.94, SD = 1.00$), $t(155) = -1.06, p = .30$. Attachment avoidance did not significantly differ between the CSA ($M = 3.90, SD = 1.15$) and non-CSA group ($M = 3.55, SD = 1.13$), $t(155) = -1.76, p = .08$. Thus, the second hypothesis was not supported.

In the third hypothesis, global self-esteem was hypothesized to be lower in individuals who had experienced CSA than those who did not experience CSA. Global self-esteem approached a significant difference between CSA ($M = 28.04, SD = 5.65$) and non-CSA groups ($M = 30.00, SD = 5.76$), $t(155) = 1.94, p = .054$, such that the CSA group had lower levels of

global self-esteem than the non-abused group. Hypothesis 3 was not supported, but results were in the expected direction.

The fourth hypothesis predicted that sexual self-esteem would be lower in individuals in the CSA group than individuals in the non-CSA group. However, sexual self-esteem did not significantly differ between CSA ($M = 145.88$, $SD = 29.86$) and non-CSA groups ($M = 145.44$, $SD = 26.52$), $t(154) = -.09$, $p = .93$. Hypothesis 4 was not supported.

The fifth hypothesis stated that subjective well-being would be lower in participants who had experienced CSA than those who did not experience CSA. Individuals who experienced CSA ($M = 31.93$, $SD = 7.18$) reported a significantly lower level of positive affect than individuals who did not experience CSA ($M = 35.24$, $SD = 6.64$), $t(155) = 2.82$, $p = .005$. Individuals who were in the CSA group ($M = 26.93$, $SD = 7.00$) experienced a significantly higher level of negative affect than individuals who were in the non-CSA group ($M = 22.88$, $SD = 7.86$), $t(155) = -3.09$, $p = .002$. Lastly, satisfaction with life approached a significant difference between the CSA ($M = 20.88$, $SD = 7.27$) and non-CSA group ($M = 23.08$, $SD = 6.18$), $t(155) = 1.95$, $p = .053$, such that those in the CSA group had lower life satisfaction than those in the non-CSA group. Hypothesis 5 was supported.

Finally, the sixth hypothesis stated that global self-esteem, sexual self-esteem, attachment avoidance, attachment anxiety, and subjective well-being would mediate the relationship between CSA and sexual revictimization. Using a parallel mediation model, this study tested the mediating effects of the above variables. Parallel mediation assumes that all four constructs, attachment, global self-esteem, sexual self-esteem, and subjective well-being are affecting the relationship between CSA and sexual assault at the same point in time. The first

pathways, on the left half, in the mediation model use ordinary least squares regression to see if experiences of CSA are predictive of increased attachment insecurity and decreased global self-esteem, sexual self-esteem, and subjective well-being. The other pathways, on the right half, in the mediation model use logistic regression due to the dichotomous nature of the outcome variable, sexual assault. This analysis determines if the mediating variables are predictive of later sexual assault. Logistic regression also analyzed if CSA predicts later sexual assault while controlling for the mediating variables. The unstandardized regression coefficients, or slopes, for direct and indirect effects are shown in Figure 2. Contrary to what was expected, the indirect effects showed that attachment avoidance, attachment anxiety, global self-esteem, sexual self-esteem, and subjective well-being did not mediate the relationship between CSA and sexual assault. Bootstrapping was used to test the significance of the indirect effects using Hayes's (2013) PROCESS macro. Specifically, the sample of 156 participants was used as a population reservoir from which to draw, with replacement, 10,000 samples of $N = 156$. PROCESS computes unstandardized indirect effects for each bootstrapped sample so the 95% confidence interval may be determined. In this analysis, sexual assault was the dependent variable, CSA the independent variable, and global self-esteem, sexual self-esteem, attachment avoidance, attachment anxiety, positive affect, negative affect, and satisfaction with life were the potential mediators. The correlations between the mediating variables and sexual assault are reported in Table 1. The results of this analysis are presented in Figure 2 and the indirect effects with 95% confidence intervals are provided in Table 2. Overall, the sixth hypothesis was not supported as none of the indirect effects were significant.

Table 1.

Correlations between attachment, global self-esteem, sexual self-esteem, positive affect, negative affect, satisfaction with life, sexual assault

	1	2	3	4	5	6	7	8
1. Attachment Anxiety	-							
2. Attachment Avoidance	.46*	-						
3. Global self-esteem	-.32*	-.56*	-					
4. Sexual self-esteem	-.48*	-.53*	.52*	-				
5. Positive Affect	-.12	-.22*	.39*	.20*	-			
6. Negative Affect	.38*	.42*	-.51*	-.56*	-.20*	-		
7. Satisfaction with Life	-.33*	-.25*	.50*	.31*	.45*	-.37*	-	
8. Sexual Assault	.23*	.28*	-.18*	-.24*	-.11	.30*	-.14	-

Note * $p < .05$

Table 2.

Mediation analysis reporting indirect effects and 95% confidence intervals

Mediator	Indirect Effect	Lower-level Confidence Interval	Upper-level Confidence Interval
Attachment Anxiety	0.02	-0.08	0.25
Attachment Avoidance	0.13	-0.02	0.51
Global self-esteem	-0.07	-0.43	0.10
Sexual self-esteem	-0.01	-0.22	0.14
Positive Affect	0.01	-0.27	0.31
Negative Affect	0.17	-0.09	0.56
Satisfaction with Life	-0.01	-0.31	0.23

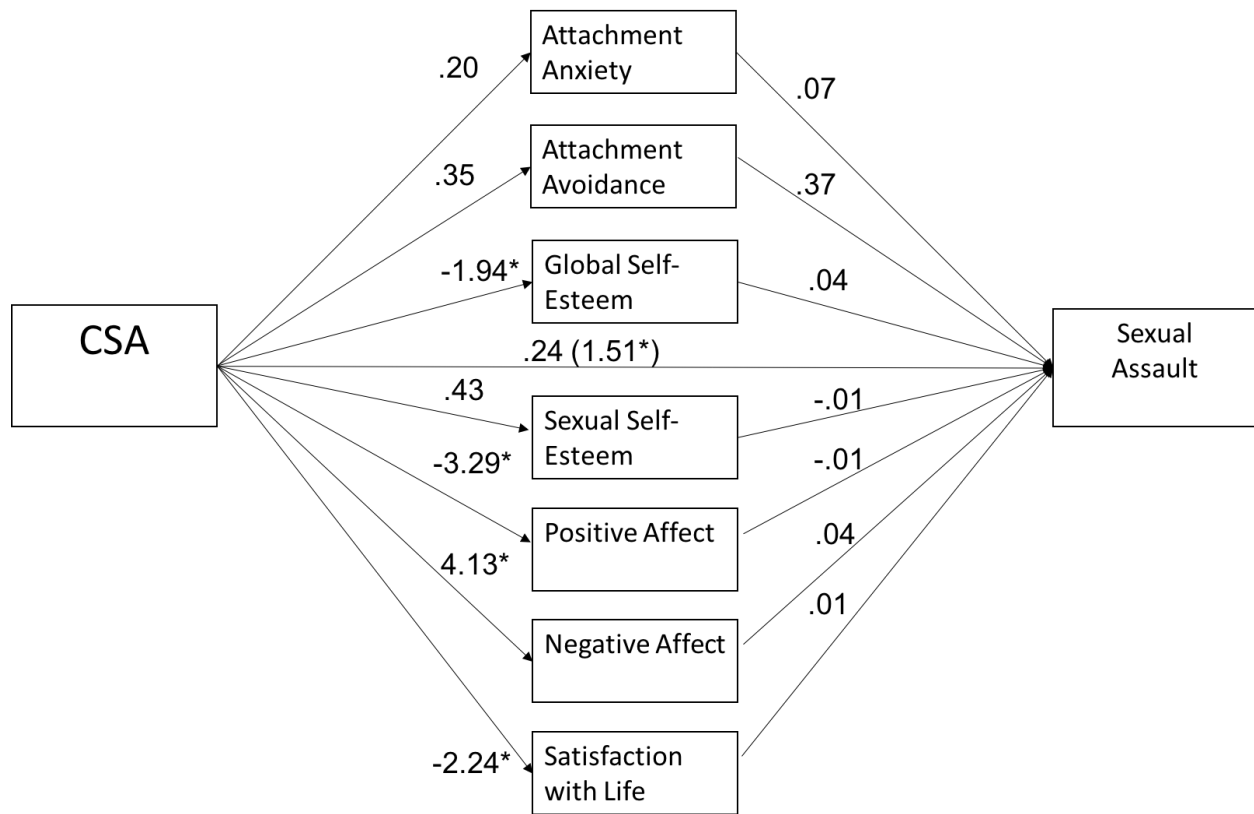


Figure 2. Unstandardized regression coefficients for the relationship between CSA and sexual assault as mediated by attachment anxiety, attachment avoidance, global self-esteem, sexual self-esteem, positive affect, negative affect, and satisfaction with life. The unstandardized regression coefficient between CSA and sexual assault, controlling for global self-esteem, sexual self-esteem, attachment anxiety, attachment avoidance, positive affect, negative affect, and satisfaction with life, is in parentheses. * $p < .05$

CHAPTER V: DISCUSSION

Understanding the impact of CSA is a multifaceted task due to the various influential dynamics. The results of this study indicate that childhood sexual abuse and sexual assault against women is a common experience. Of the women whom participated, nearly one-third reported CSA, and almost half reported experiencing sexual assault, making the negative outcomes associated with these experiences all the more relevant. Therefore, an understanding of the magnitude and impact of CSA and sexual assault is vital. The current study investigated how CSA was related to global self-esteem, sexual self-esteem, attachment, subjective well-being, and sexual assault. Formulated from the Traumagenic Dynamic Model (Finkelhor & Browne, 1985), attachment and self-esteem, global and sexual, were examined as aspects of betrayal and stigmatization, respectively. Additionally, subjective well-being was used to examine how CSA may be related to the way individuals view their world. The results suggested that experiences of CSA were associated with lower global self-esteem as well as lower levels of subjective well-being. Although the study found that these were negative outcomes of CSA, they were not found to mediate the relationship between CSA and sexual assault in adulthood.

Support for Hypothesis 1 was found. Female college students who reported a history of CSA were more likely to be sexually revictimized in adulthood than women who did not report a history of CSA. Notably, almost 75% of individuals who reported being sexually abused in childhood reported being sexually assault during adulthood. In addition, nearly half of the women, regardless of experiences of CSA, reported experiencing sexual assault in adulthood. While this supports previous research, this finding shows an alarmingly high rate of revictimization as well as sexual assault. Past research has found that rates of revictimization of those who have experienced CSA to be around 50% (Walker, Freud, Ellis, Fraine, & Wilson,

2017). However, Reese-Weber and Smith (2011) found a revictimization rate of CSA victims to be 75%, a much higher number that is consistent with this study. The exact nature of higher rates of sexual assault and revictimization in this study is unknown; however, factors such as the current increased media coverage of this topic may play a role. While in the past, victim blaming was a cultural norm, in today's society, movements such as #MeToo and Times Up have increased awareness of sexual assault and violence towards women. Due to the growing number of social media coverage on sexual assault, it may be that survivors feel less stigmatized and more empowered to come forth with their own story. Social media has the potential to provide a platform for victims of sexual assault to be understood and for perpetrators to be held accountable for their actions. This study supports previous research on revictimization and stresses the importance of implementing treatment for CSA survivors as they may be at an increased risk for adult sexual assault.

Hypothesis 2 was not supported. Somewhat surprisingly, participants who reported a history of CSA did not report significantly higher levels of attachment anxiety or higher levels of attachment avoidance than individuals who did not experience CSA. Contrary to previous research that found that CSA was related to dismissive and fearful attachment styles in female college students (Aspelmeir, Elliott, & Smith, 2007), the association was not supported in this study. However, in a short-term longitudinal study of female college students, there was no difference found between CSA and non-CSA groups on attachment anxiety or attachment avoidance (Reese-Weber & Smith, 2011). These inconsistent findings may suggest that there are many factors impacting these results. Based on Finkelhor and Browne's (1985) traumagenic model, attachment is influenced through the dynamic of betrayal. Betrayal occurs when an individual perceives that they have been misled or lied to by a person they previously trusted.

This study did not examine whether betrayal was felt after experiencing CSA and instead used attachment as a proxy. As Bowlby (1969) postulated in his attachment theory, early experiences play a critical role in shaping the expectations and child constructs in regards to the receptiveness and trustworthiness of others. It may be that earlier experiences of CSA (i.e., during ages when childhood attachment is being rapidly developed) have a more significant impact on attachment style in comparison to CSA occurring after attachment style has been more developed. Reese-Weber and Smith (2011) suggested, it may be that CSA individuals who choose to participate in psychological studies may have fewer problems with attachment than CSA victims who chose not to participate, making them similar to non-CSA participants in terms of attachment.

Support for Hypothesis 3 was not found. Victims of CSA did not report lower levels of global self-esteem than individuals who were not victims of CSA. The current research supports previous studies that also found CSA was related to deleterious impacts on self-esteem (Canton-Cortes et al., 2012). CSA has been found to create feelings of worthlessness, self-blame, and negative affect (Bagley & Young, 1990). Self-blame is associated with the traumagenic dynamic of stigmatization, where the victim is likely to take responsibility for the abuser's actions fostering feelings of shame and guilt (Finkelhor & Browne, 1985). Stigmatization may become apparent through reduced social connection and increased isolating behaviors, which reinforces low self-esteem (Freyd, 1996). As suggested by previous research and this study, survivors of CSA are more likely to develop feelings of stigmatization and, therefore, are at a higher risk for developing long-term depression and suicidal ideation.

Support for Hypothesis 4 was not found. The CSA group did not report lower levels of sexual self-esteem than the non-CSA group. Sexual self-esteem is an aspect of global self-esteem and, therefore, is related to the concept of stigmatization. Feelings of stigmatization can

develop when victim blaming occurs and the individual is demeaned with derogatory words or actions, such as “whore” or “slut” (Mayers et al., 2003). Society’s view of the victims of CSA as well as early exposure to sexual behaviors can lead the victim to develop negative views of themselves as a sexual being (Van Bruggen et al., 2006). Past research has found that CSA has negatively impacted sexual self-esteem. Not surprisingly, past research indicates that the more severe the CSA experience (e.g., penetrative sex, use of coercion, long duration) the more likely an individual will experience negative outcomes related to sexual self-esteem (Kelly & Gidycz, 2015). However, the findings of this research indicate that the CSA group did not significantly differ from the non-CSA group on perceived levels of sexual self-esteem. It may be that students in college have the ability to restore sexual self-esteem after a traumatic event. As college students are often fairly high functioning young adults and come from higher socioeconomic backgrounds, students may possess better coping skills that allow them to have the appropriate resources to effectively handle traumatic events with less impact on one’s sexual self-esteem.

Hypothesis 5, which predicted that CSA victims would have lower levels of subjective well-being than non-CSA individuals, was supported. The CSA group reported lower levels of positive affect, higher levels of negative affect, and approached significantly lower levels of satisfaction with life than the non-CSA group. Applying Lent’s (2004) model of subjective well-being, these results suggest that CSA is a traumatic event that disrupts normal day-to-day functioning, triggering the restorative process of subjective well-being. Given that individuals who experienced CSA in this study reported negative impacts on all three domains of subjective well-being (less positive affect, more negative affect, and less satisfaction with life), it could be that they perceived CSA as a traumatic event in which they did not possess the resources to effectively cope, thus, making them more likely to have negative outcomes on their subjective

well-being. This study's results support previous research that found CSA survivors are more likely to experience symptoms of depression, anxiety, and PTSD (Roller et. al, 2009; Van Bruggen, 2006), all of which have significant impacts on positive and negative affect. Previous research also indicated that CSA is associated with negative perceptions of one's life (Becker-Lausen, Sanders, & Chinsky, 1995), again, supporting the results found in this study.

Hypothesis 6 was not supported. The relationship between CSA and sexual assault was not found to be mediated by global self-esteem, sexual self-esteem, attachment insecurity, or subjective well-being. Past research has provided ample evidence of the link between experiences of CSA and adulthood sexual revictimization (Loeb, Williams, & Siegel, 2006; Reese-Weber & Smith, 2011; Messman & Long, 1996). However, research seems to only speculate about the pathway through which it may occur. There is little prior research that has investigated the indirect pathways from CSA to sexual assault. Although the current study did not find a mediational model, research should continue to examine possible pathways between CSA and later sexual assault. There are many different factors that could explain the relationship between CSA and sexual assault, such as mental health problems and increased sexualized behaviors that develop as a result of CSA experiences. However, these are only speculations. The history of experiencing CSA cannot be changed, but finding the outcomes that may help explain a later vulnerability for adult sexual assault may help clinicians in addressing CSA.

Limitations

The present study should be interpreted with the following limitations in consideration. First, the majority of the participants (62.7%) identified as Caucasian/White meaning that the results of this study may not be generalizable to other ethnic minorities. Research suggests that the manner in which different factors, such as attachment and self-esteem, contribute to sexual

victimization varies due to cultural and environmental differences across ethnic groups (Jimenez & Abreu, 2003). This research also indicated that a child's response to the experience of CSA is related to cultural reactions. For example, Jimenez and Abreu (2003) propose that in Hispanic cultures, female virginity is highly valued making experiences of CSA extremely detrimental to cultural norms. Thus, the results may be different when comparing different racial and ethnic groups.

Second, the data for this study were comprised only from female college students. The results may be different if non-college students were included in the population sample. For example, previous research indicates that college students may engage in more risky behaviors than non-students, such as binge drinking and riskier sexual behaviors, and, thus, may be more inclined to experience sexual assault during their time in college (Lindo et al., 2018).

Additionally, college students are fairly high functioning and, therefore, may be a more resilient group of individuals allowing the participants to be able to cope with traumatic events more effectively.

Third, the studied variables comprised self-report measures and, therefore, may have been influenced by factors such as participant's current mood, social desirability, and answering biases. Although this is a limitation, self-reports are still the best method available for collecting data related to personal experiences.

Fourth, mediation usually requires a longitudinal design to show that one event happened before the other. This study made strong assumptions about the direction of relationships between variables but was not conducted in a longitudinal manner. Therefore, caution should be taken when applying the results of a mediation analysis. There may not be sufficient evidence

to conclude that childhood abuse came before attachment style and other variables.

Implementing a longitudinal design would give more robust support for the reliability of the results found.

Finally, perhaps due to the sample of participants for the current study, results that are often supported with research were not supported. College students are often fairly high functioning young adults and other studies have investigated these relationships with a more clinical sample of participants, who tend to have more diverse levels of functioning overall.

Future Research

Regardless of the limitations of the study, the study provides important information about the outcomes of CSA and later sexual revictimization. This study provides information about the severe negative implications of childhood sexual abuse on adulthood adjustment and experiences of sexual assault. Future research could continue to build upon this research in numerous ways. First, future research would benefit from including a more diverse population in terms of ethnicity and non-college students. Having a more diverse population would permit researchers to make more generalizable implications and understand factors about a population that may lead individuals to have more severe consequences from CSA and adult sexual assault. Second, future studies could benefit from examining the relationship between CSA and sexual assault in a longitudinal design. A longitudinal method would be helpful in clarifying and establishing change in attachment, subjective well-being, self-esteem, and sexual self-esteem as a result of CSA. Third, future researchers could investigate the severity of CSA (i.e., duration, relationship to perpetrator, age of victimization, type of sexual act) to determine if they are critical aspects of the CSA experience that increase the likelihood an individual will experience psychological difficulties and other negative consequences. This could provide information about the severity

of CSA and severity of sexual assault that may impact the development of subjective well-being, sexual and global self-esteem, and attachment insecurity.

Strengths and Contributions

This study has several strengths. The present study adds to the expanding research that examines how negative outcomes associated with CSA may lead to increased vulnerability to sexual assault in adulthood. Subjective well-being and sexual self-esteem are factors that have only recently begun to be examined in regards to CSA and sexual assault. This study furthered the existing literature on the impacts of CSA by illuminating the relationship between CSA and lower subjective well-being. Prior to this research, little was known about the impact of subjective well-being as a result of CSA. This study provided information about the different domains of subjective well-being that are related to CSA in hopes of developing a better understanding of the internal processes of CSA survivors. This study expands the current knowledge on the relationship between CSA, attachment, self-esteem, sexual self-esteem, subjective well-being, and sexual assault.

Conclusion

The present study examined the relationship between CSA and sexual assault by examining the potential mediating factors of subjective well-being, attachment, self-esteem, and sexual self-esteem. Understanding the pathways in which CSA may lead to later revictimization can have important clinical implications. The findings of this study will help to inform mental health practitioners who work with survivors of CSA. The results of the current study provide clinicians with a greater depth of understanding regarding the importance of helping individuals who have experienced CSA in regards to increasing their subjective well-being. For example, it may assist clinicians who work with victims of CSA to better understand their clients' struggles

and develop relevant treatment goals and strategies. Clinicians may wish to consider using Lent's (2004) restorative model of well-being in order to understand the process by which subjective well-being was impacted and how feelings of decreased positive affect and increased negative affect developed. Understanding the negative outcomes following experiences of CSA can help researchers and clinicians alike implement effective treatment modalities to prevent future revictimization.

Similar to subjective well-being, self-esteem can be an imperative factor for mental health interventions. Improving a CSA victim's self-esteem is a critical for decreasing stigmatization and self-blame (Canton-Cortes et al., 2012) and preventing the development of depression and suicidal ideation (Bagley & Young, 1990). There are a variety of modalities that target the ongoing development of self-esteem by implementing healthy, effective coping strategies that reduce depression, anxiety, and other negative psychological outcomes commonly associated with CSA (Fergusson, McLeod, & Horwood, 2013). Fortunately, modalities that target self-esteem already exist in individual, group, and family contexts. However, this study highlights the importance of those practices and the need for utilization of these practices with victims of CSA. Although the factors of attachment, global and sexual self-esteem, and subjective well-being did not mediate the relationship between CSA and sexual assault, the direct pathway between CSA and sexual assault was not found to be significant when controlling for the other mediators. Therefore, there is still an alarming amount of research to be done in order to understand what does mediate that relationship and what preventative measures can be taken to help victims of CSA from experiencing revictimization. Future research should continue to examine the variables in the current study, as well as other variables, to find possible mediating influences on the relationship between CSA and sexual assault.

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APPENDIX A: INFORMED CONSENT

Research Participant Informed Consent – APPLE

PLEASE READ THIS DOCUMENT CAREFULLY. SIGN YOUR NAME BELOW ONLY IF YOU AGREE TO PARTICIPANT. YOUR SIGNATURE IS REQUIRED FOR PARTICIPATION IN THIS RESEARCH. YOU MUST BE AT LEAST 18 YEARS OF AGE TO PARTICIPATE.

Description of the Study: This research study will ask you to answer several questions regarding your cognitive and emotional states, and your past childhood adolescent, and adulthood experiences. You will need a pen or pencil, the survey, and a manila envelope to complete the study. You will be asked to complete the survey, place it inside the manila envelope, and then place it in the box at the front of the room marked “Surveys”.

Nature of Participation: You will spend approximately 45-60 minutes completing the survey measures.

Purpose of the Study: The purpose of the study is to examine how cognitive and emotional states of young adults are associated with specific past experiences, including adverse past experiences.

Possible Risks: There may be a risk of uncomfortable feelings and/or painful thoughts/memories when answering the survey questions. However, please note that you may drop out of the study at any time, or skip any questions you do not want to answer. Also, researchers will provide you with a list of local resources who can help you. If needed, researchers will take you to the Student Counseling Services building. Although code numbers will be used and no identifying information will be on your questionnaire packet, there is also a slight risk of loss of confidentiality.

Possible Benefits: This study will allow participants to contribute to the understanding of cognitive and emotional states among young adults as an outcome of past experiences. If you desire to be informed about the outcome of this study, you can contact the researcher through the information listed below

Compensation for your time: You will receive extra credit in a psychology course through the SONA system. You will receive extra credit simply by the virtue of coming to your appointment; you are free to withdraw your participation at any time without penalty.

Confidentiality: Your questionnaire packet has been assigned a code number that will protect your identity. This signed informed consent document will be kept separate from your questionnaire packet. All data will be kept in secure files, in accord with the standards of the University, Federal regulations, and the American Psychological Association. Finally, it is no individual person’s responses that interest us; we are studying people in general.

Opportunities to Question: Any technical questions about this research may be directed to Dr. Marla Reese-Weber at (309) 438-3743. Any questions regarding your rights as a research participant or research-related injuries may be directed to ISU’s Office of Research Ethics and Compliance (309) 438-2529.

Opportunities to Withdraw at Will: Your participation is completely voluntary. If you decide now or at any point to withdraw this consent or stop participation, you are free to do so at no penalty to yourself. You are also free to skip questions you do not want to answer and continue participating without loss of benefits.

Opportunities to be Informed of Results: In all likelihood, the results will be fully available around the summer of 2018. If you wish to be told the results of this research, please contact Dr. Marla Reese-Weber at (309) 438-3743. She will either meet with you to discuss the results or direct you to a copy of the results. In addition, there is a chance that the results from this study will be published in a scientific psychology journal, which would be available in many libraries. In such an article, participants would be identified in general terms such as “college students”.

I consent to participate in this study.

Signature

Date

Print Name

Date

APPENDIX B: DEMOGRAPHIC QUESTIONNAIRE

1. Gender
 - a. Male
 - b. Female
 - c. Other (please specify) _____

2. Age: _____

3. Ethnic Background:
 - a. Asian/Asian-American
 - b. Black/African American
 - c. Hispanic/Latino
 - d. White/Caucasian
 - e. Other (please specify) _____

4. Sexual Orientation
 - a. Heterosexual (straight)
 - b. Gay
 - c. Lesbian
 - d. Bisexual
 - e. Other (please specify) _____

5. Relationship Status
 - a. Single
 - b. Dating someone
 - c. Living with significant other
 - d. Married
 - e. Divorced
 - f. Separated
 - g. Widowed
 - h. Other (please specify) _____

6. If Applicable: Year in School
 - a. Freshman
 - b. Sophomore
 - c. Junior
 - d. Senior
 - e. Graduate Student—Master's
 - f. Graduate Student—Doctorate

7. How intense are your current religious beliefs?
- Not religious
 - Moderately religious
 - Very religious
8. How many times have you attended a church service over the last month? _____ time(s)
9. Current Living Arrangements
- Live with parents
 - Live in the residence halls
 - Live in an apartment/house alone
 - Live in an apartment/house with friends
 - Live in an apartment/house with romantic partner
 - Other (please specify) _____
10. Family Status:
- Biological/adopted parents are currently married (skip next question)
 - Biological/adopted parents are currently divorced
 - Single Parent
 - Other, please specify _____
11. Following the divorce of your biological/adopted parents, with whom did you live the majority of the time?
- Mother
 - Mother and Step-father
 - Father
 - Father and Step-mother
 - Other, please specify _____
12. Mother/stepmother's Highest Education:
- Some high school, but no degree
 - High School degree
 - Two years college
 - Four years college (Bachelor's degree)
 - Graduate Degree (Master's degree or higher)
13. Father/stepfather's Highest Education:
- Some high school, but no degree
 - High School degree
 - Two years college
 - Four years college (Bachelor's degree)
 - Graduate Degree (Master's degree or higher)
14. How many biological/adopted/step-siblings do you have? _____

APPENDIX C: DEBRIEFING STATEMENT

The purpose of the study is to examine if past sexual experiences are related to the cognitive and emotional states of young adults. We expect that individuals with histories of specific sexual experiences will have varying levels of self-esteem, relationship attachment, and life satisfaction compared to individuals without such experiences.

If after completing this study you are upset or would like to discuss your experiences, you may contact: Illinois State University's Student Counseling Services at (309) 438-3655 or <http://counseling.illinoisstate.edu>. The PATH crisis center for a referral at (309) 827-4005 or 1-800-570-7284. The National Sexual Assault Hotline at 1-800-656-4673 or <http://www.rainn.org/>. Please remember that your responses are confidential and all data will be kept in secure files. If you have any questions regarding this study or would like more specific information regarding this study, please contact Dr. Marla Reese-Weber at (309) 438-3743 or mjreese@ilstu.edu. You may also contact the graduate students conducting this study to satisfy a Master's Thesis in psychology, Kristen Silbert at knsilbe@ilstu.edu or Jade Spaulding, at jaspaul@ilstu.edu. Any questions regarding your rights as a research participant or research-related injuries may be directed to ISU's Office of Research Ethics and Compliance (309) 438-2529.

Please do not share the purpose or expectations of this study with other classmates, as we may continue to do research in the future. Thank you again for your participation! Good luck with the rest of your semester!