



SCHOOL of
GRADUATE STUDIES
EAST TENNESSEE STATE UNIVERSITY

East Tennessee State University
Digital Commons @ East
Tennessee State University

Electronic Theses and Dissertations

Student Works

5-2010

Disclosure, Social Reactions to Disclosure, and Mental Health Outcomes Among Adult Child Sexual Abuse Victims.

Holly E. Hopson

East Tennessee State University

Follow this and additional works at: <https://dc.etsu.edu/etd>



Part of the [Social Psychology and Interaction Commons](#)

Recommended Citation

Hopson, Holly E., "Disclosure, Social Reactions to Disclosure, and Mental Health Outcomes Among Adult Child Sexual Abuse Victims." (2010). *Electronic Theses and Dissertations*. Paper 1685. <https://dc.etsu.edu/etd/1685>

This Thesis - Open Access is brought to you for free and open access by the Student Works at Digital Commons @ East Tennessee State University. It has been accepted for inclusion in Electronic Theses and Dissertations by an authorized administrator of Digital Commons @ East Tennessee State University. For more information, please contact digilib@etsu.edu.

Disclosure, Social Reactions to Disclosure, and Mental Health Outcomes Among Adult Child
Sexual Abuse Victims

A thesis

presented to

the faculty of the Department of Psychology

East Tennessee State University

In partial fulfillment

of the requirements for the degree

Master of Arts in Psychology

by

Holly Elizabeth Hopson

May 2010

Stacey Williams, Ph.D., Chair

Chris Dula, Ph.D.

Jon Ellis, Ph.D.

Keywords: Child Sexual Abuse, Disclosure, Social Reactions, Mental Health Outcomes

ABSTRACT

Disclosure, Social Reactions to Disclosure, and Mental Health Outcomes Among Adult Child Sexual Abuse Victims

by

Holly Elizabeth Hopson

Child sexual abuse (CSA) is a frequent problem in American society associated with a wide range of negative mental health outcomes. Some evidence suggests that disclosure may moderate the relationship between CSA and mental health. However, the specific reactions a victim receives following disclosure may directly affect the impact that disclosure has on mental health. The current study directly and simultaneously evaluated the roles of disclosure and social reactions in relation to mental health outcomes. The sample consisted of 652 undergraduate students at East Tennessee State University who completed an on-line, self-administered questionnaire. Forty-four (6.75%) of the participants reported experiencing CSA. Of the 44 participants who experienced CSA, 18 (41%) disclosed their abuse. Results indicated that, counter to our hypotheses; neither CSA nor disclosure was significantly related to anxiety and depression. However; as predicted, negative social reactions were significantly related to both anxiety and depression among those who had disclosed.

ACKNOWLEDGEMENTS

First and foremost, I need to thank my parents for their unwavering support throughout this entire process. Without your encouragement and faith in me, none of this would be possible. I also want to thank my committee chair Dr. Stacey Williams for the enormous amount of help and guidance she has provided throughout this project, as well as my committee members Dr. Chris Dula and Dr. Jon Ellis for their support and insight in pulling this project together.

Thank you!

CONTENTS

	Page
ABSTRACT.....	2
ACKNOWLEDGMENTS.....	3
LIST OF TABLES.....	6
Chapter	
1. INTRODUCTION.....	7
What is Child Sexual Abuse?.....	8
Prevalence and Incidence of CSA.....	9
CSA among College Students	11
Mental Health Outcomes of CSA.....	12
Disclosure of CSA.....	14
The Role of Disclosure in CSA-Related Mental Health Outcomes.....	17
Social Reactions to Disclosure of CSA and Mental Health.....	18
The Present Study.....	21
2. METHOD.....	22
Sample.....	22
Measures.....	22
Demographics.....	22
Childhood Sexual Abuse (CSA).....	22

Disclosure.....	23
Social Reactions.....	24
Mental Health Outcomes.....	24
Procedure.....	25
Analysis.....	25
3. RESULTS.....	27
4. DISCUSSION.....	30
Implications.....	33
Conclusion.....	34
REFERENCES.....	36
APPENDIXES.....	43
Appendix A: Demographics.....	43
Appendix B: CSA.....	44
Appendix C: Disclosure.....	46
Appendix D: Social Reactions Questionnaire.....	47
Appendix E: Symptom Checklist.....	50
VITA.....	52

LIST OF TABLES

Table	Page
1. Descriptive Statistics and Intercorrelations.....	27
2. Regression Analysis Summary for CSA (N=44).....	28
3. Regression Analysis Summary for Disclosure.....	28
4. Regression Analysis Summary for Social Reactions.....	29

CHAPTER 1

INTRODUCTION

Child sexual abuse (CSA) is a frequent but complex problem in American society that is associated with a wide range of negative psychosocial outcomes. Despite the multiple efforts by law enforcement, social service agencies, and researchers, the exact prevalence of child sexual victimization and the full extent of the psychological consequences into adulthood are not completely understood. Prevalence studies have generally concluded that 20% (1 in 5) of adult women and 5% to 10% of adult men have been sexually abused at some time in their lives (Finkelhor, 1994), although estimates vary by specific study. Similarly, self-reported cases of CSA in women range from 15%- 33% (Filipas & Ullman, 2006). Commonly reported negative mental health outcomes in adult survivors of CSA include depression, low self-esteem, anxiety, phobias, eating disorders, self-destructive behaviors, substance abuse, somatoform disorders, and PTSD (Cole & Putnam, 1992). Yet, other less frequently studied factors may play a role in determining these potentially negative outcomes of the CSA experience.

Some evidence suggests that one potential moderator of the relationship between CSA and mental health outcomes is disclosure of the abuse. That is, the outcomes of CSA may be differentiated by whether or not an individual has confided in others about the abuse experience. Further, some prior literature suggests that the reactions a victim receives following disclosure of abuse may directly affect the psychological outcomes associated with the abuse and the disclosure (Lovett, 2004; Ullman, 2003). The literature on CSA, disclosure, and reactions to disclosure is presented in the following pages to provide the rationale for the present thesis.

What is Child Sexual Abuse?

Throughout the last couple of decades, there has been a variety of definitions of CSA. In 1986, Browne and Finkelhor defined CSA as “two overlapping but distinguishable types of interaction: (a) forced or coerced sexual behavior imposed on a child, and (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (a common definition of “much older” is 5 or more years)” (pg. 66). Although a variety of specific sexual activities have been considered to be CSA (intercourse, oral-genital contact, attempted intercourse, fondling of genitals (directly or through clothing), exhibitionism or exposing children to adult sexual activity or pornography, and the use of a child for prostitution or pornography (Putnam, 2003), there is a general lack of societal consensus regarding activities that constitute sexual abuse, as well as discrepancies in age limits. Thus, for legal and research purposes definitions of CSA have simply required two elements; (1) sexual activities (contact and noncontact) involving a child and (2) an “abusive condition” based on the abuser (large age gap, position of authority or caretaker, coercion or force).

Although some previous researchers have included age ranges of up to 18 years, it has been documented that the majority of CSA happens before age 12, which leads some researchers to focus on sexual acts prior to age 12. Putnam (2003) reported that approximately 54% of CSA happens between the ages of 4 and 11 and Finkelhor (1994) estimates that over 60% of sexual abuse occurs before 12 years of age. Additionally, the National Incident-based Reporting System (NIBRS) data showed one third of all sexual assaults (including adult) involved a victim under 12 years of age and, 1 in 7 victims was under age 6 (Bureau of Justice Statistics, 2000). One additional reason research focuses on age 12 years and under stems from the suggestion that a developmental perspective be taken in the study of CSA; presumably the effects of CSA at

different developmental points in a child's life influence his or her outcomes (Cole & Putnam, 1992). In line with these perspectives, the present study examined sexual abuse that occurred at 12 years of age and under (i.e. retrospectively reported) and the relationship between these experiences and adult outcomes. In addition, CSA was defined according to Browne and Finkelhor (1986) as: “(a) forced or coerced sexual behavior imposed on a child, or (b) sexual activity between a child and a much older person, whether or not obvious coercion is involved (a common definition of “much older” is 5 or more years)” (pg. 66).

Prevalence and Incidence of CSA

Child sexual abuse (CSA) is a significant problem in American society. Despite fervent efforts by law enforcement, social service agencies, and researchers, the actual number of children sexually victimized each year still is not completely known. At least in part this is due to the methods of assessing CSA. Typically, CSA is assessed in one of two ways; incidence or prevalence. Prevalence statistics describe the portion of adults who have had abuse experiences at some point in their lifetime. These data come from surveys in which adults respond with their retrospective reports of CSA experiences (Finkelhor, 1994). On the other hand, incidence data reflect the number of CSA cases that professionals (e.g. social service agencies, medical professionals, law enforcement) report encountering in a year and are collected mostly from the National Incidence Study (NIS), the National Child Abuse and Neglect Data System (NCANDS), child protection agencies, and law enforcement. Consequently, the prevalence and incidence rates of CSA reported in the literature have historically been inconsistent.

Before the late 1970s reported cases of child sexual abuse were a rarity. In the following decades, however; the *incidence* of reported CSA increased dramatically in number of

victimizations. The U.S. Department of Health and Human Services reported a 67% (931,100 to 1,553,800) increase in incidence of all forms of child abuse from 1986 to 1993 based on cases in the National Incidence Studies (U.S. Department of Health and Human Services, 1996).

Although there has been some literature indicating that officially- reported cases of CSA have declined (Jones, Finkelhor, & Kopiec, 2001), it is important to note that most statistics are based solely on reported cases that are known and substantiated by child protection agencies and law enforcement officials. Therefore, incidence rates obtained from formal reports may be underestimates because reported victims account for only a small proportion of those who are victimized.

In a review article of 19 adult retrospective studies, Finkelhor (1994) found *prevalence* rates ranging from 2% (George & Winfield-Laird, as cited in Finkelhor, 1994) to 62% (Wyatt, 1985), depending on the research design. Siegel, Sorenson, Golding, et al. (1986) reported prevalence rates of CSA before age 16 and found that 7% of females and 4% of males indicated that they had suffered abuse (Siegel et al., as cited in Finkelhor, 1994). However, Finkelhor (1994) noted that although there is variation among studies, prevalence studies have generally been able to conclude that 20% (1 in 5) of women and 5%-10% of men have experienced abuse at some time in their lives. Variation in the prevalence rates of CSA can be attributed to a variety of research-related issues including clinical vs. nonclinical samples, selection and response rate, the definition used (including age cut-offs), and the method by which the abuse history is obtained (Putnam, 2003). For example, studies using clinical samples may report higher rates of CSA because all participants have previously diagnosed psychological ailments and the definitions of abuse used in clinical studies tend to be more homogenous in their experiences than those used in nonclinical studies (Collings, 1995). Response rates can affect the

validity and generalizability of findings in that there is a possibility that those who choose not to participate have experienced CSA. Varying definitions of CSA and the diversity of sexual experiences included in those definitions have led to a wide-range of prevalence estimates (Edwards et al., 2001). Furthermore, there are differences in rates as a result of the methods used in obtaining abuse histories of participants. Prevalence rates for studies using health histories (i.e. medical records) are notably lower than those using histories collected for the purposes of CSA research mainly due to the types of screening questions used. There are also differences in rates between self-report surveys and structured interviews, resulting in a broader range of reported prevalence rates.

CSA Among College Students

A commonly studied population in the CSA literature is college-aged men and women, with the primary focus on women (i.e. Back & Lips, 1998; Jensen, Gulbrandsen, Mossige, Reichelt, & Tjersland, 2005; Ullman & Filipas, 2005). Still, reported CSA prevalence rates for these individuals are as unclear and varying as the rates presented for the general population. The same reasons for differing rates apply to the college student population as well. Using Finkelhor's Sexual Victimization Questionnaire (1979), which assesses both contact (e.g. touching, fondling, vaginal or anal penetration) and noncontact (e.g. invitation to do something sexual, showing his or her private parts) forms of abuse, Murthi and Espelage (2005) found in their sample of college women (N=116) that 90% reported having at least one type of sexual experience before the age of 12, and 12.9% reported having at least one type of sexual experience prior to age 12 with an "adult" over age 16. In a review article, Messman and Long (1996) reported prevalence rates ranging from 22% (Fromuth, as cited in Messman & Long, 1996) to 54% (Gidycz, Coble, Latham, & Layman, 1993) within college samples. Of the 20

reviewed articles, eight studies assessed CSA using surveys five of which specifically used Finkelhor's Sexual Victimization Questionnaire (1979). The remainder of the researchers conducted interviews in an attempt to assess CSA (Messman & Long, 1996). Despite the inconsistent prevalence data, the research has demonstrated college students are an important group to study because of the potentially high prevalence and wide range of CSA experiences they report (Murthi & Espelage, 2005). In addition, Rind and Tromovitch (1997) provided some evidence for similarities in CSA rates between college samples and the general population. Thus, because of the general representation of the college student reported CSA experiences with those of the general population and the relative ease with which to collect data, CSA and CSA-related outcomes were examined among college students at a southeastern regional university.

Mental Health Outcomes of CSA

Not surprisingly, the range of mental health outcomes associated with CSA is as broad and varied as the nature of the abuse situations. Following a trend of heightened awareness regarding CSA as a major public health problem, in the last 20 years researchers have identified a multitude of negative psychological outcomes associated with CSA experiences (Molnar, Buka, & Kessler, 2001). Among the general population, initial effects resulting from the abuse include fear, anxiety, depression, anger, and aggression (Finkelhor, 1990). These effects seemingly affect adult outcomes as well. Cole and Putnam (1992) identified a number of common effects found in adult CSA survivors including depression, low self-esteem, anxiety, phobias, eating disorders, self-destructive behaviors, substance abuse, somatoform disorders, and PTSD. Others have reported that women with a history of CSA are 3-4 times more likely to report lifetime major depression than women who are not abused (Putnam, 2003). In a study using the National Comorbidity Survey Molnar et al. (2001) found retrospectively reported CSA

to be associated with current adult depression, anxiety, and PTSD symptomology across all adult age groups. The prevalence of psychiatric disorders is markedly higher among those respondents reporting a history of CSA compared with those who had no history of CSA, 39.3% (CSA) vs. 21.3% (no CSA history) (Molnar et al., 2001). In his 10 year research update, Putnam (2003) noted that, as a group, CSA victims exhibit problems with affect regulation, somatization, cognitive distortions, and socialization as well as issues related to sense of self regardless of their psychiatric diagnosis.

Similar mental health outcomes have been shown among studies incorporating college student samples specifically. Within college samples Urquiza and Crowley (1986) found that both men and women reported significant increases in levels of depression, sleep problems, PTSD symptoms, low self-esteem, drug use, sexual problems, and suicidal ideation. Sedney and Brooks (1984) noted in their study of 301 college women that participants reporting CSA experiences were more likely to report symptoms of depression than those in the control group of no CSA (65% vs. 43%) and more likely to have been hospitalized for depression (18% vs. 4%). Similarly, Briere and Runtz (1985) surveyed 278 undergraduate women and found that CSA victims expressed more depressive symptoms in the year prior to the study than participants who were not abused. Suicidality has been reported within a number of college samples as well (Bryant & Range, 1997; Cole & Putnam, 1992; Peters & Range, 1995).

Another variable to consider within the college population is revictimization. Studies have indicated that within the college population a history of CSA often results in a vulnerability to adult sexual assault (e.g.; Messman & Long, 1996; Nurcombe, 2000). Gibson and Leitenburg (2001) found in their study of 825 undergraduate women aged 16-28 years that 36% of victims of young adult sexual assault also reported a history of CSA. Yet, revictimization rates among

college populations might actually be low compared to the overall population because the students are for the most part young and have not had a lot of time to be victimized as adults. Nonetheless, such high rates of revictimization indicate that there may be a psychological and emotional vulnerability linked to CSA that leads to victimization as an adult, even among the college population. Importantly, although revictimization can be linked with negative outcomes as well, the results indicate that child sexual abuse appears to have a stronger relationship to outcomes (e.g. current suicidal ideation) than adult abuse experiences (Thakkar, Gutierrez, Kuczen., & McCanne, 2000). Thus, there is a wide range of negative CSA-related mental health outcomes.

The literature suggests that specific aspects of the abuse experience both during and after can affect the existence or the severity of negative psychological outcomes (e.g. Finkelhor, 1990; Nurcombe, 2000). That is, there may be specific factors that impact or moderate how CSA is related to outcomes. In the following sections, two potential explanations for those negative outcomes are explored, namely disclosure and social reactions to disclosure.

Disclosure of CSA

One potential variable in the relationship between CSA and MH outcomes is disclosure of the abuse to others. Disclosure was defined as “the telling of abuse”, regardless of the specific individual (formal or informal network) to whom the victim discloses (Lovett, 2004; Ullman, 2003). The literature on prevalence of disclosure is reviewed first, followed by the mental health consequences of disclosure.

Studies have shown that victims frequently either fail to disclose the abuse or delay disclosure for years (Ullman, 2003). It is estimated that less than one in four CSA victims disclose to someone immediately following the abuse (Paine & Hansen, 2002). Therefore, the

literature mainly focuses on lifetime disclosures of CSA, the majority of which comes from retrospective reports among adult survivors of CSA. For example, in a national survey of adult men and women, Finkelhor, Hotelling, Lewis, and Smith (1990) noted that 33% of women and 42% of men never disclosed their abuse experience to anyone. Banyard, Arnold, and Smith (2000) reported that 72% of women disclosed their CSA experiences, but 47% of those who disclosed did not disclose to anyone for 5 years or more following the abuse (Ullman, 2003). One study found the latency of disclosure indicates delays ranging from 3 to 18 years (Allagia & Kirshenbaum, 2005). In a community sample involving 3,000 women Mullen, Martin, Anderson, Romans-Clarkson, and Herbison (1993) specifically noted delays in disclosure and found that 37% of the victims disclosed within the first year following the abuse, 10% disclosed 1-10 years after, 24% disclosed beyond 10 years, and 28% had never disclosed.

Within college samples researchers have reported low disclosure rates as well. In their review article, London, Bruck, Ceci, and Shuman (2005) noted disclosure rates among college samples ranging from 24% to 38%. Similarly, Arata (1998) found in a sample of college women, that only one third of victims disclosed at the time of the abuse and, of those who disclosed, 40% of the victims told only one person. In contrast, Kellogg and Hutson (1995) reported that 85% of the young adult victims in their study had disclosed, although the timing of the disclosure was not specified.

It is important to note that differences in disclosure rates within any population may be affected by factors such as age, duration, and severity of abuse (Arata, 1998; London et al., 2005; Lovett, 2004; Paine & Hansen, 2002). For example, Arata (1998) reported that participants reporting contact abuse were less likely to disclose than those victims who suffered noncontact abuse (e.g. exhibition or request to do something sexual). In addition, within her sample of 204

women Arata (1998) noted that disclosure was more likely for those respondents reporting a shorter duration of abuse, as opposed to those who reported abuse durations of 1 year or more (41%-1 day or less vs. 17%- 1 year or more). Furthermore, the victim's relationship to the abuser has been shown to affect the disclosure process as well (Allagia & Kirshenbaum, 2005; Finkelhor et al., 1990). Allagia and Kirshenbaum (2005) noted that relationship to the abuser is one inhibiting factor to disclosure and "the more closely related victims are to the perpetrator, the less likely they are to disclose child sexual abuse (pg. 228)."

There are other documented factors that influence a victim's decision to disclose or not to disclose as well. Jensen et al. (2005) reported that many disclosures are determined by prompts from others and open opportunities to talk. They further noted that many victims found it difficult to disclose because of a lack of suitable private situations and that disclosure was easier when CSA was addressed (Jensen et al., 2005). Consequently, cultural factors and family dynamics can be inhibiting factors to disclosure by depriving CSA victims of such open opportunities to talk. For example, Allagia and Kirshenbaum (2005) reported that "disclosure may be inhibited in families whose cultures hold taboos and negative attitudes about sexuality and that place a high premium on preservation of family (pg. 228)". Other noted reasons for nondisclosure are embarrassment and shame, fear of negative reactions and consequences, protecting others, and threats made by the abuser (Ullman, 2003). Although the reasons for disclosure are numerous, for the purpose of the present thesis, disclosure was examined more generally (i.e. disclosure vs. nondisclosure) and its ability to define the relationship between childhood experiences and adult mental health outcomes; rather than predictors of disclosure.

The Role of Disclosure in CSA-Related Mental Health Outcomes

Ultimately, a victim's decision to disclose or not to disclose has the potential to affect mental health outcomes of CSA. Disclosure of traumatic events in general has been associated with decreased distress and physical symptoms (Arata, 1998). Pennebaker (1985) has reported that not talking about a traumatic experience is related to an increase of physiological activity and risk of physical disease. Similarly, Arata (1998) found that women who did not disclose their CSA experiences had an increase in avoidant, intrusive, and PTSD symptoms related to the abuse compared to women who did disclose. Further, Wyatt and Newcomb (1990) reported that nondisclosure of CSA was predictive of negative long-term outcomes such as adjustment, emotional, sexual, and relationship-specific problems. Thus, disclosure of abuse can directly affect the relationship between child sexual abuse and adult mental health outcomes.

While disclosure is generally thought to help precipitate more positive psychological outcomes, there is evidence that disclosure itself does not guarantee an increase in positive psychological health. In addition, Pennebaker (1985) noted that disclosure can have negative effects depending on the response of the person to whom the victim discloses. In a study on college students in particular Ullman and Filipas (2005) found that while 44.9% of CSA victims said that disclosing was beneficial, 40.2% reported indifference, and 15% said that disclosing made them feel worse. DeFrancis (1969) noted that 64% of his sample expressed guilt, which was largely related to disclosure rather than the abuse experience itself. In their review article on CSA disclosures, McNulty and Wardle (1994) noted that disclosure is related to a worsening of psychiatric systems, rejecting responses from others, and an elevated risk of disorders.

The equivocal nature of the findings highlights the possibility that other variables such as characteristics or outcomes of the disclosure may determine mental health outcomes. In this way,

the social reaction(s) a victim receives following disclosure may be a primary factor explaining the positive or negative effects of disclosure in relation to child sexual abuse and adult psychological functioning. In her review of disclosure, Ullman (2003) wrote that “The relationship of disclosure to the psychological outcomes of the child is unclear, and the results are mixed, but it appears that it may depend on the reactions of those told about the abuse, as well as other contextual factors.” (pg. 93).

Social Reactions to Disclosure of CSA and Mental Health

Broadly, social reactions encompass the feedback a person receives from other people following an activity or experience (Arata, 1998). There is a myriad of both positive and negative social reactions to CSA disclosures. Reported positive reactions include belief, validation, not being blamed, protectiveness, listening, willingness to talk about the effects of the abuse, accepting attitude, as well as assuring the abuse will not reoccur (instrumental support). Conversely, commonly reported negative reactions include disbelief, blame, ignoring the victim (refusing to talk), minimization, parental rejection, neglect, indifference, hostility, avoidance, punishment, stigma, accusations of lying, and a lack of action to stop the abuse (Ullman, 2003).

Many victims receive negative reactions and feedback from the person to whom they disclose. Ullman (2003) reported that many adult CSA survivors indicated that their childhood disclosures were met with negative reactions such as blame or encouraging secrecy, and many times the abuse did not end following disclosure. For example, in a study of 83 confirmed cases of CSA records showed that in 20 of the 83 cases the confidant did not report the abuse to anyone following the victim’s disclosure (Paine & Hansen, 2002). In addition, Jensen et al. (2005) reported that in their sample of 22 CSA victims and their families most people to whom the victims disclosed initially responded with shock and looked for alternative explanations for

why the child was indicating abuse (ie: “maybe she just dreamt this up”, “he has always fantasized a lot”) (pg. 15).

These various social reactions can have a profound impact on the outcomes associated with the disclosure process and the victim’s abuse experiences. The victim may have a heightened vulnerability to psychological consequences depending on the nature of the reaction from others. The results of the existing literature suggest that the reaction a victim receives following disclosure of abuse directly affects the psychological outcomes associated with the abuse (Lovett, 2004; Ullman, 2003). Ullman (2003) reported that a variety of studies have documented a wide range of negative reactions to CSA disclosures as well as the significant adverse effects of negative reactions on psychosocial adjustment and psychological health. There is evidence to suggest that negative social reactions are more important in determining psychological adjustment than other factors and are more predictive of psychological symptoms than the abuse characteristics themselves (Lange et al., 1999; Ullman, 2003). In their study of female college students Everill and Walker (1994) reported that women who received a negative reaction to disclosure had greater symptomology including dissociative and PTSD symptoms, than both women who did not disclose and those who disclosed and received a positive response. Browne and Finkelhor (1986) noted one study in which children who received negative reactions to disclosure from their parents had more than double the number of symptoms compared to those who did not. Conversely, Arata (1998) found that children who received a positive reaction to disclosure are less likely to have negative psychological outcomes and Lovett (2004) reported that maternal responses that are protective and supportive are associated with greater mental health and current functioning. Furthermore, supportive reactions to disclosure have been shown

to lead to positive current adjustment, a decrease in PTSD symptoms, and an increase in self-esteem in adult CSA victims (Arata, 1998; Ullman, 2003).

There is evidence that reactions to disclosure and the subsequent distress may also differ according to the victim's relationship with the individual to whom they disclosed. In particular, there have been reports that the reaction victims receive from their mothers following a disclosure is pivotal with regards to their mental health (Arata, 1998; Jensen et al., 2005; Lovett, 2004). Jensen et al. (2005) noted that in their study of disclosure children are highly sensitive toward their mothers' thoughts, feelings, and needs and that they make decisions about what they can and cannot discuss based on adults' reactions. In a study of treatment-seeking women mothers (and other adults) were least likely to believe the disclosure information, while friends were more likely to believe that abuse actually occurred (Ullman, 2003). Furthermore, one study revealed that parental reactions were worse than those from other support sources even when age of disclosure was controlled for. Although friends appear to be the most supportive to CSA victims (Ullman, 2003), Arata (1998) reported that negative reactions received from peers were still related to negative psychological symptomology.

It is evident from past research that the reaction a victim receives during and following a CSA disclosure can be a powerful variable in the complex relationship between CSA, disclosure, and mental health outcomes. Ullman (2003) recognized that reactions to abuse are significant factors that influence a victim's recovery from abuse and further noted that in lieu of the prevalence of negative reactions to disclosures and the psychological effects on the victims more research is needed to evaluate outcomes of CSA in the context of other people's reactions.

The Present Study

The purpose of the current study was three-fold: (1) to evaluate the relation between CSA and adult mental health outcomes; (2) to explore the link between disclosure and adult mental health outcomes among victims of CSA; and (3) to examine the link between the social reactions to disclosure and adult mental health outcomes. Specifically, it was hypothesized that CSA would be predictive of negative adult mental health outcomes and that disclosure would change the relationship between CSA and adult mental health outcomes. Further, it was hypothesized that negative social reactions to disclosure would result in more negative adult psychological outcomes compared to disclosures met with positive or supportive reactions. Thus, social reactions would moderate the relation between disclosure and adult mental health outcomes.

In order to evaluate these hypotheses, data were analyzed from an existing online survey that examined a variety of childhood and adult sexual and relationship violence experiences among college students. The online survey included an examination of CSA, disclosure, reactions, and mental health, which are directly in line with the literature reviewed in this thesis.

CHAPTER 2

METHOD

Sample

The sample consisted of 652 undergraduate students at a southeastern regional university who completed an on-line, self-administered questionnaire on *Life Events and Sexual Experiences among College Students* through the University's Medical School Software. A total of 424 (65%) of the sample were women and 224 (34.4%) were men. Their ages ranged from 18 to 55 ($M = 21$, $SD = 5$). Out of 652 participants who completed the questionnaire, 44 (6.75%) indicated that they had experienced CSA (based on our definition; see below).

Measures

Demographics

Participant demographic information on gender, age, and marital status were assessed. Demographic questions were included in order to describe the sample as well as to examine whether these variables should be included as possible statistical control variables in the main analysis.

Childhood Sexual Abuse (CSA)

Childhood sexual abuse was assessed using questions from Finkelhor's (1979) Sexual Victimization Questionnaire (SVQ). The SVQ is a widely used measure (e.g. Gajarsky, 1991; Gidycz et al., 1993; Murthi & Espelage, 2005; Runtz, 1987) that assesses characteristics of CSA experiences and includes both contact (e.g. fondling, penetration) and noncontact (e.g. invitation to do something sexual, exhibitionism) abuse. The SVQ includes questions based on sexual experiences before age 12.

A label of CSA was based on 1) the sexual act and 2) the condition of the experience. Items on the SVQ that assessed the sexual act included questions such as, “Did you have any of the following experiences before age 12 (e.g. kissing and hugging in a sexual way, another person fondling you in a sexual way, intercourse)?” Items that assessed the condition of the experience included questions related to age at the time of the act, age of the abuser, and whether or not threats or force were used.

In the present study CSA was determined based on whether or not participants indicated “yes” to experiencing a sexual act at age 12 or earlier as well as whether or not the condition of a 5- year age difference was present or force or coercion had been used. For example, participants who indicated a sexual experience before age 12 by someone who threatened them would be included in the CSA category regardless of an age difference, whereas a participant who indicated that at age 12 he or she was abused by someone 3 years older would not be included because the condition of a 5- year age difference or force or coercion was not met. Only those participants indicating childhood sexual experiences at or before age 12 and met the condition for CSA were included in the CSA category.

Disclosure

Disclosure was assessed using one question from Finkelhor’s SVQ (1979) that asked the participants to indicate who they told (if anyone) about their sexual experience. The response options included; 1= No one, 2= Mother, 3= Father, 4= Other Adult, 5= Brother/Sister, 6= Friend, and 9= N/A. Disclosure was evaluated by “yes” (disclosed to someone) and “no” (no disclosure attempts). A disclosure variable was determined by an affirmative response to options 2 through 6, versus 1 or 9.

Social Reactions

Retrospective reports of the reactions participants received at the time of disclosure were measured using the Social Reactions Questionnaire (SRQ, Ullman, 2000). The SRQ is a questionnaire that asks participants to indicate how often they received a variety of different reactions at the time they disclosed their CSA. Two subscales of social reactions, (1) positive or supportive and (2) negative were used in the present study. The positive or supportive subscale includes instrumental support (e.g. actual assistance), information support (e.g. provided info or opinion or advice), emotional support (e.g. love, caring, etc.), and validation or belief. The negative subscale of the SRQ examines the responses of: taking control of the victim's decisions, victim blame, treating the victim differently (e.g. pulling away), distraction, and egocentric behavior (e.g. focusing on his or her own needs rather than those of the victim). Each item employs a 5-point Likert scale with response options of 0=never and 4=always. The SRQ has been shown to have good internal consistency reliability with alphas ranging from .77 to .93. In addition, the SRQ has good construct validity and convergent validity (Ullman, 2000). For the present study, analyses indicated good reliability for positive ($\alpha=.98$) and negative ($\alpha=.92$) reactions. Therefore, mean scores for positive and negative reactions were calculated for use in main analysis.

Mental Health Outcomes

Adult mental health outcomes were measured using the Trauma Symptom Checklist-40 (TSC-40, Briere & Runtz, 1989). The TSC-40 is a 40-item self-report measure that evaluates symptomology. The scale consists of six subscales: Anxiety, Depression, Dissociation, Sexual Abuse Trauma Index (SATI), Sexual problems, and Sleep Disturbance. Symptom items are rated by frequency of occurrence within the 2 months prior to the assessment and are measured on a 4-

point Likert scale with response options from 0 = never to 3 = often (Briere, 1996). For the purpose of the present study the outcomes related to the subscales of anxiety and depression were specifically analyzed because, as outlined above, they tend to be the most commonly experienced outcomes of CSA. The TSC-40 has been shown to have solid reliability with subscale alphas ranging from .66 to .77 and alphas for the entire scale averaging between .89 and .91 (Briere, 1996). For the present study analysis revealed good reliability for anxiety ($\alpha=.79$) and depression ($\alpha=.77$). Therefore, mean scores of the subscales were calculated.

Procedure

Participants signed up for the study via the Psychology Department's online system (SONA). Participants selected the study from a list of other research opportunities available. The study was entitled *Life Events and Sexual Experiences Among College Students* and an instruction statement was shown to the participant online prior to the study. By continuing past the first page to complete the survey participants acknowledged informed consent and that they were over the age of 18. Moderate extra credit was offered by professors for total time spent participating in research using SONA. The survey took approximately 1 hour to complete. Data were collected from Spring of 2006 through Spring of 2008.

Analysis

Descriptive statistics for all study variables were calculated. A preliminary goal of the study was to descriptively report rates of CSA and disclosure among victims. In addition, prior to conducting main analyses demographic characteristics were tested for use as possible control variables in the analysis. In order to test the main study hypotheses regression analyses were conducted. In the first analysis, a simple regression was conducted by regressing mental health outcomes on CSA exposure. In the second analysis mental health was regressed on disclosure

among CSA victims only in order to explore the link between disclosure and adult mental health problems among those participants who were victimized. In the third analysis mental health outcomes were regressed on social reactions among those CSA victims who had disclosed.

Given an average or medium effect size, to reach adequate power of .80 a sample size of 55 is needed when conducting simple regressions. In the present sample, there were 44 individuals who classified as experiencing CSA. This sample size falls short of the needed 55 to attain adequate power. However, even with this smaller number, power still is .71. In addition, prior research – although it does not report directly their effect sizes – has indicated that the strength of association between social reactions to disclosure and mental health outcomes is quite strong. As such, if we find a large effect size, then adequate power (.80) will be met.

CHAPTER 3

RESULTS

Out of 652 participants who completed the questionnaire, 44 (6.75%) indicated that they had experienced CSA (based on our definition; see below). Women accounted for 36 (81.82%) of CSA victims while only 8 (18.18% of victims; 3.13% of overall sample) males reported having experienced CSA. Victims' ages ranged from 18 to 55 ($M= 27, SD= 10$). Of the 44 participants who experienced CSA, 41% (18) indicated that they had disclosed their abuse. Descriptive statistics including means and correlations for the continuous study variables are presented in Table 1.

Table 1. *Descriptive Statistics and Intercorrelations*

<u>Descriptives on CSA Victims</u>	<u>M</u>	<u>SD</u>	1	2	3	4
1. Anxiety (N= 44)	1.08	.619	----	.850**	----	----
2. Depression (N= 44)	1.15	.606	----	----	----	----
<u>CSA Victims Who Disclosed</u>						
1. Anxiety (N=18)	1.13	.778	----	.899**	.241	.428
2. Depression (N=18)	1.11	.701	----	----	.277	.415
3. Positive reactions (N=18)	2.47	1.26	----	----	----	-.311
4. Negative reactions (N=18)	.969	.671	----	----	----	----

** $p < .01$

Next, main study hypotheses were tested. Prior to these analyses demographic characteristics were examined for use as possible control variables. Results showed that none of the demographic variables were significantly related to main study variables; therefore, demographics were not used in subsequent analyses. In order to test Hypothesis 1, that CSA

would be predictive of negative adult mental health outcomes, mental health variables of anxiety and depression were regressed on CSA. As seen in Table 2, the results indicated that CSA was not predictive of adult negative mental health outcomes.

Table 2. *Regression Analysis Summary for CSA (N=44)*

Variable	Anxiety				Depression			
	b	SE	β	R ²	b	SE	β	R ²
CSA	.084	.218	.015	.000	.064	.220	.011	.000

* $p < .05$

Next, in order to test hypothesis 2, that disclosure would be related to adult mental health outcomes among victims of CSA, mental health outcomes of anxiety and depression were regressed on disclosure only among those who had CSA. As reported in Table 3, results showed that disclosure was not significantly related to depression or anxiety.

Table 3. *Regression Analysis Summary for Disclosure*

Variable	Anxiety				Depression			
	b	SE	β	R ²	b	SE	β	R ²
Disclosure (N=18)	.097	.191	.078	.006	-.062	.188	-.051	.003

* $p < .05$

Finally, in order to test hypothesis 3, that negative social reactions to disclosure would result in more negative adult psychological outcomes, compared to disclosures met with positive or supportive reactions, mental health outcomes of anxiety and depression were regressed on

positive and negative social reactions among those CSA victims who had disclosed. Results of these regression analyses indicated that, as expected, negative social reactions to CSA disclosures were significantly and positively related to anxiety and depression. As shown in Table 4, negative social reactions accounted for 33.8% of the variance in anxiety and 35.5% of the variance in depression.

Table 4. *Regression Analysis Summary for Social Reactions*

Variable	Anxiety				Depression			
	b	SE	β	R ²	b	SE	β	R ²
Negative reaction (N= 18)	.621	.265	.557	.338*	.571	.241	.555	.355*
Positive reaction (N=18)	.246	.141	.414		.246	.128	.450	

* $p < .05$

CHAPTER 4

DISCUSSION

The purpose of the current study was three-fold: to evaluate the relation between CSA and adult mental health outcomes; to explore the link between disclosure and adult mental health outcomes among victims of CSA; and to examine the link between the social reactions to disclosure and adult mental health outcomes. Based on the findings of prior work it was hypothesized that (1) CSA would be predictive of adult mental health outcomes; (2) that disclosure would be related to adult mental health outcomes; and (3) that social reactions would be related to adult mental health outcomes. Specifically, it was hypothesized that CSA would be predictive of negative adult mental health outcomes and that disclosure would change the relationship between CSA and adult mental health outcomes. Further, it was hypothesized that negative social reactions to disclosure would result in more negative adult psychological outcomes compared to disclosures met with positive or supportive reactions. Results indicated that counter to hypotheses neither CSA nor disclosure was significantly related to the negative mental health outcomes of anxiety and depression. As predicted, negative social reactions were significantly and positively related to both anxiety and depression among those who had disclosed their CSA experiences.

The main finding of the present study is that negative social reactions accounted for 33.8% of the variance in anxiety and 35.5% of the variance in depression, indicating that social reactions to disclosure play a role in psychological outcomes of adult CSA survivors. This supports prior literature that has suggested the reactions a victim receives following disclosure of abuse can directly affect the psychological outcomes associated with the abuse and can be more

predictive of psychological symptoms than characteristics of the abuse itself (Lange et al., 1999; Lovett, 2004; Ullman, 2003).

Surprisingly, results of the present study indicated that disclosure of the abuse was not significantly related to the mental health outcomes of depression and anxiety. This lack of finding is contrary to research conducted by Arata (1998), which reported that women who did not disclose their CSA experiences had an increase in avoidant and intrusive negative mental health symptoms related to the abuse compared to women who did disclose. Similarly, Wyatt and Newcomb (1990) reported that nondisclosure of CSA was predictive of negative long-term outcomes. Yet, other findings of past research evidence that disclosure is related to a worsening in clinically depressive and psychotic symptoms (DeFrancis, 1969; McNulty & Wardle, 1994). McNulty and Wardle (1994) noted that “There is a possibility that disclosure itself may be a primary cause in the development of psychiatric symptoms” (pg. 551).

Although it had been hypothesized that nondisclosure would be related to increased anxiety and depression, the lack of significant finding may provide further support for the third study hypothesis that is the social reactions a victim receives following a disclosure are predictive of mental health outcomes. Indeed, in line with Ullman (2003), “The relationship of disclosure to the psychological outcomes of the child is unclear... it appears that it may depend on the reactions of those told about the abuse...” (pg. 93). In addition, Pennebaker (1985), acknowledged that disclosure can have negative effects on cognitive and emotional factors (i.e. depression, anger, fatigue, irrational fears) depending on the response of the person to whom the victim discloses.

Results of the current study also indicated that there was no statistically significant relationship between CSA and adult mental health outcomes. This result is surprising and is not

supported by previous literature; most researchers agree there is a link between CSA experiences and negative mental health outcomes in adulthood (Cole & Putnam, 1992; Finkelhor, 1990; Molnar et al., 2001; Putnam, 2003; Urquiza & Crowley, 1986). Considering possible explanations, it may be relevant that some researchers find groups of CSA victims that report few or no negative mental health outcomes (Finkelhor, 1990). Tong, Oates, and McDowell (1987) reported 36% of a sample of CSA victims in the normal range on the Child Behavior Checklist, and Mannarino and Cohen (1986) found 31% of their sample to be “symptom-free”. Perhaps some CSA victims in the present study are asymptomatic because of characteristics such as less severe abuse and receiving a positive or supportive social response and adequate support. If so, it may be that those individuals coping well cancel out the overall impact of CSA on mental health outcomes. Or, perhaps specific characteristics of the abuse are more predictive of mental health in adulthood than whether someone experienced abuse or not. Indeed, Putnam (2003) noted that due to the diversity of CSA experiences, a wide range of outcomes is to be expected.

The two findings of the present study that are contrary to hypotheses (i.e. CSA and disclosure in relation to mental health outcomes) also might be explained by the somewhat restrictive definition of CSA that was used. The definition required a sexual experience at age 12 or earlier, as well as a 5- year age difference or force or coercion. This resulted in only 44 out of 652 participants qualifying for the study (based on our definition). Similar definitions have been widely used in prior literature and provide a means of distinguishing between actual CSA and consensual sexual experiences by either children of the same age or adolescents who may be sexually experienced. Rind et al. (1997) reported, in their meta-analysis that 88% of the studies reviewed used an age limit similar to the one in the present study and 59% used a definition that

required a 5- year age gap, again, similar to the one in the present study. Yet, it could be that some individuals in the study encountered sexual experiences prior to adulthood that they would consider abusive but were not categorized as having CSA because the experiences were outside of the 12- year age requirement and the 5 year age difference. Furthermore, social desirability bias could be possible in that some respondents may have experienced CSA but feared disclosing regardless of the confidential and anonymous nature of the questionnaire. In line with this possibility, it may be that the relation with mental health outcomes between those with CSA and those without CSA is muddled. Similarly, a more thorough measurement of disclosure and age of disclosure would be helpful for a clearer assessment of the relation between disclosure and mental health symptoms among CSA victims.

Additionally, the data were collected retrospectively within a presumably high-functioning population of college students, which could indicate less overall negative mental health outcomes than in the general population or in clinical populations. Further, the retrospective nature of this survey means that much time has lapsed since the abuse experience and could have impacted the relations between CSA, disclosure, and mental health. It is possible that adults retrospectively reporting on CSA experiences may have misdated their abuse or did not recall disclosing as a child (London et al., 2005).

Implications

The findings of the present study may have implications in the areas of research and practical application. The strong relationship between social reactions to disclosure and negative mental health outcomes highlights the importance of the role social reactions play in the mental health of victims of CSA. As a consequence, this research may evidence a need for educating people about the potentially devastating psychological consequences that may result from their

reactions to someone's disclosure of abuse. Considering that CSA victims could potentially disclose to a wide variety of people – law enforcement, social service workers, health care workers, school officials, therapists, parents, and friends – it seems that such an education effort at the public health level might prove beneficial.

In addition, while we are beginning to understand the negative outcomes of negative reactions to disclosure, more research is needed to identify possible positive outcomes resulting from positive reactions. By better understanding the dynamics of CSA disclosures and subsequent reactions, we may subsequently identify ways to positively influence the mental health outcomes of victims through intervention.

Although there is a plethora of research on CSA and some on possible moderating and mediating variables in the link between CSA and mental health, more research is needed. In particular, there is a strong need for consensus on what activities, age limits, and age differences between victim and perpetrator constitute CSA (Edwards et al., 2001; Rind et al., 1997). Due to the varying characteristics of experience, the incidence and prevalence rates as well as links with outcomes are inconsistent. Further, it may be that perceptions of sexual encounters by children differ depending on specific age or developmental stage. Defining CSA according to different age groups being evaluated (e.g., even within the under age 12 requirement) may be helpful.

Conclusion

In conclusion, despite its limitations, the present study found a strong, statistically significant relationship between social reactions and negative adult mental health outcomes. These findings confirm the need for more research into the psychological effects of social reactions on CSA victims at the time of disclosure and highlight the need for educational

resources for both professionals and parents in order to facilitate positive outcomes in the wake of CSA and disclosure.

REFERENCES

- Alaggia, R. (2004). Many ways of telling: Expanding conceptualizations of child sexual abuse disclosure. *Child abuse & neglect, 28*, 1213-1227.
- Alaggia, R., & Kirshenbaum, S. (2005). Speaking the unspeakable: Exploring the impact of family dynamics on child sexual abuse disclosures. *Families in Society, 86*, 227-234.
- Arata, C. M. (1998). To tell or not to tell: Current functioning of child sexual abuse survivors who disclosed their victimization. *Child Maltreatment, 3*(1), 63-71.
- Back, S., & Lips, H. M. (1998). Child sexual abuse: Victim age, victim gender and observer gender as factors contributing to attributions of responsibility. *Child abuse & neglect, 22*, 1239-1252.
- Banyard, V. L., Arnold, S., & Smith, J. (2000). Childhood sexual abuse and dating experiences of undergraduate women. *Child Maltreatment, 5*(1), 39-48.
- Briere, J. (1996). Psychometric review of the Trauma Symptom Checklist 40. In B.H. Stamm (Ed.), Measurement of stress, trauma, and adaptation. Lutherville, MD: Sidran Press.
- Briere, J., & Runtz, M. (1989). The Trauma Symptom Checklist (TSC-33): Early data on a new scale. Journal of Interpersonal Violence, 4, 151-163.
- Browne, A., & Finkelhor, D. (1986). Impact of child sexual abuse: A review of the research. *Psychological bulletin, 99*(1), 66-77.

- Bryant, S. L., & Range, L. M. (1997). Type and severity of child abuse and college students' lifetime suicidality. *Child Abuse and Neglect, 21*, 1169-1176
- Cole, P. M., & Putnam, F. W. (1992). Effect of incest on self and social functioning: A developmental psychopathology perspective. *Journal of consulting and clinical psychology, 60*, 174-184.
- Collings, S. J. (1995). The long-term effects of contact and noncontact forms of child sexual abuse in a sample of university men. *Child Abuse and Neglect, 19*(1), 1-6.
- Edwards, V. J., Anda, R. F., Nordenberg, D. F., Felitti, V. J., Williamson, D. F., & Wright, J. A. (2001). Bias assessment for child abuse survey: Factors affecting probability of response to a survey about childhood abuse. *Child Abuse & Neglect, 25*, 307-312.
- Everill, J. & Waller, G. (1994). Disclosure of sexual abuse and psychological adjustment in female undergraduates. *Child Abuse & Neglect, 19*, 93-100.
- Filipas, H. H., & Ullman, S. E. (2006). Child sexual abuse, coping responses, self-blame, posttraumatic stress disorder, and adult sexual revictimization. *Journal of Interpersonal Violence, 21*, 652-672.
- Finkelhor, D. (1979). *Sexually victimized children* (pgs. 157-184). New York: Free Press.
- Finkelhor, D. (1990). Early and long-term effects of child sexual abuse: An update. *Professional Psychology: Research and Practice, 21*, 325-330.

Finkelhor, D. (1994). Current information on the scope and nature of child sexual abuse. *Future of Children, 4*(2), 31-53.

Finkelhor, D., Hotaling, G., Lewis, I. A., & Smith, C. (1990). Sexual abuse in a national survey of adult men and women: Prevalence, characteristics, and risk factors. *Child abuse & neglect, 14*(1), 19-28.

Gibson, L. E., & Leitenberg, H. (2001). The impact of child sexual abuse and stigma on methods of coping with sexual assault among undergraduate women. *Child Abuse and Neglect, 25*, 1343-1361.

Gidycz, C.A., Coble, C.N., Latham, L., & Layman, M.J. (1993). Sexual assault experience in adulthood and prior victimization experiences: A prospective analysis. *Psychology of Women Quarterly, 17*, 151-168.

Jensen, T. K., Gulbrandsen, W., Mossige, S., Reichelt, S., & Tjersland, O. A. (2005). Reporting possible sexual abuse: A qualitative study on children's perspectives and the context for disclosure. *Child abuse & neglect, 29*, 1395-1413.

Jones, L. M., Finkelhor, D., & Kopiec, K. (2001). Why is sexual abuse declining? A survey of state child protection administrators. *Child abuse & neglect, 25*, 1139-1158.

Kellogg, N. D. & Huston, R. L. (1995). Unwanted sexual experiences in adolescents: Patterns of disclosure. *Clinical Pediatrics, 34*, 306-312.

- Lange, A., De Beurs, E., Dolan, C., Lachnit, T., Sjollema, S., & Hanewald, G. (1999). Long-term effects of childhood sexual abuse: Objective and subjective characteristics of the abuse and psychopathology in later life. *Journal of Nervous and Mental Disease, 187*, 150-158.
- London, K., Bruck, M., Ceci, S. J., & Shuman, D. W. (2005). Disclosure of child sexual abuse: What does the research tell us about the ways that children tell? *Psychology, 11*(1), March 2005.
- Lovett, B. B. (2004). Child sexual abuse disclosure: Maternal response and other variables impacting the victim. *Child & Adolescent Social Work Journal, 21*, 355-371.
- Mannarino, A.P., & Cohen, J.A. (1986). A clinical-demographic study of sexually abused children. *Child Abuse and Neglect, 10*, 17-23.
- McNulty, C., & Wardle, J. (1994). Adult disclosure of sexual abuse: A primary cause of psychological distress? *Child Abuse and Neglect, 18*, 549-555.
- Messman, T. L., & Long, P. J. (1996). Child sexual abuse and its relationship to revictimization in adult women: A review. *Clinical psychology review, 16*, 397-420.
- Molnar, B. E., Buka, S. L., & Kessler, R. C. (2001). Child sexual abuse and subsequent psychopathology: Results from the national comorbidity survey. *American Journal of Public Health, 91*, 753-760
- Mullen, P. E., Martin, J. L., Anderson, J. C., Romans-Clarkson, S. E., & Herbison, G. P. (1993). Childhood sexual abuse and mental health in adult life. *British Journal of Psychiatry, 163*, 721-732.

- Murthi, M., & Espelage, D. L. (2005). Childhood sexual abuse, social support, and psychological outcomes: A loss framework. *Child abuse & neglect, 29*, 1215-1231.
- Nurcombe, B. (2000). Child sexual abuse I: Psychopathology. *Australian and New Zealand Journal of Psychiatry, 34*(1), 85-91.
- Paine, M. L., & Hansen, D. J. (2002). Factors influencing children to self-disclose sexual abuse. *Clinical psychology review, 22*, 271-295.
- Pennebaker, J. W. (1985). Traumatic experience and psychosomatic disease: Exploring the roles of behavioural inhibition, obsession, and confiding. *Canadian Psychology, 26*, 82-95.
- Peters, D. K., & Range, L. M. (1995). Childhood sexual abuse and current suicidality in college women and men. *Child Abuse and Neglect, 19*, 335-341.
- Putnam, F. W. (2003). Ten-year research update review: Child sexual abuse. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*, 269-278.
- Rind, B., & Tromovitch, P. (1997). A meta-analytic review of findings from national samples on psychological correlates of child sexual abuse. *Journal of sex research, 34*, 237-255.
- Sedney, M. A., & Brooks, B. (1984). Factors associated with a history of childhood sexual experience in a nonclinical female population. *Journal of the American Academy of Child Psychiatry, 23*, 215-218.

- Siegel, J., Sorenson, S., Golding, J., et al. (1986). The prevalence of childhood sexual assault: The Los Angeles epidemiologic catchment area project. *American Journal of Epidemiology*, *126*, 1141-1153.
- Thakkar, R. R., Gutierrez, P., Kuczen, C. L., & McCanne, T. R. (2000). History of physical and/or sexual abuse and current suicidality in college women. *Child Abuse and Neglect*, *24*, 1345-1354.
- Tong, L., Oates, K., & McDowell, M. (1987). Personality development following sexual abuse. *Child Abuse and Neglect*, *11*, 371-383.
- Ullman, S. E. (2000). Psychometric characteristics of the social reactions questionnaire: A measure of reactions to sexual assault victims. *Psychology of Women Quarterly*, *24*, 257-271.
- Ullman, S. E., & Filipas, H. H. (2005). Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors. *Child Abuse and Neglect*, *29*, 767-782
- Ullman, S. E. (2003). Social reactions to child sexual abuse disclosures: A critical review. *Journal of Child Sexual Abuse*, *12*(1), 89-121.
- Urquiza, A., & Crowley, C. (1986, May). *Sex differences in the survivors of child sexual abuse*. Paper presented at the 4th National Conference on the Sexual Victimization of Children, New Orleans.

U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.
National Incidence Studies. Washington, DC: DHHS, 1996.

U.S. Department of Justice, Bureau of Justice Statistics. *National Incidence-Based Reporting System (NIBRS)*. Washington, DC: US. GPO, 2000.

Wyatt, G. E. & Newcomb, M. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting & Clinical Psychology*, 58, 6, 758-767.

APPENDIXES

APPENDIX A

Demographics

1. Your gender:

1. Male
2. Female

2. Your age _____

3. Marital Status:

1. Single
2. Married
3. Separated or divorced
4. Widowed

APPENDIX B

CSA

(Finkelhor, 1979)

4. It is now generally realized that most people have sexual experiences as children and while they are growing up. Some of these are with friends and playmates, and some with relatives and family members. Some are very painful and upsetting, and some are not. Some influence people's later lives and sexual experiences, and some are practically forgotten.

We would like you to try to remember the sexual experiences you had while growing up. By "sexual", we mean a broad range of things, anything from playing "doctor" to sexual intercourse – in fact, anything that may have seemed sexual to you.

5. Did you have any of the following experiences before the age of 12 (6th grade)
(Check any that apply)

- a. An invitation or request to do something sexual. _____
- b. Kissing and hugging in a sexual way. _____
- c. Another person showing his/her sex organs to you. _____
- d. You showing your sex organs to another person. _____
- e. Another person fondling you in a sexual way. _____
- f. You fondling another person in a sexual way. _____
- g. Another person touching your sex organs _____
- h. You touching another person's sex organs. _____
- i. Intercourse, but without attempting penetration. _____
- j. Intercourse. _____
- k. Other: _____

Now we want you to think of three sexual experiences – or however many up to three – that you had before the age of 12 with an adult (a person over 16) including strangers, friends, or family members like cousins, aunts, uncles, brothers, sisters, mother or father. Pick the three most important and answer the following questions about them. Take one experience and answer all the questions on the 2 pages that pertain to it, and then return and answer the same questions about experience #2 and #3.

No such experience [] Go to next section

Experience #1

Experience #2

Experience #3

6. About how old were you at the time?

7. Approximate age of the other person(s)?

8. What happened?

(Circle 1 for Yes or 0 for No for each line.)

a. An invitation to do something sexual

b. Kissing and hugging in a sexual way

c. Other person showing his/her sex organs to you

d. You showing your sex organs to another person

e. Other person fondling you in a sexual way

f. You fondling another person in a sexual way

g. Other person touching your sex organs

h. You touching another person's sex organs

i. Intercourse, but without attempting penetration

j. Intercourse

Other: please mention

9. Did other person(s) threaten or force you?

[1= Yes 2 = A little 3= No]

APPENDIX C

Disclosure

(Finkelhor, 1979)

10. Who did you tell about this
experience at the time?

1 = No one 2 = Mother 3 = Father 4 = Other Adult
5 = Brother/Sister 6 = Friend 9 = N/A

APPENDIX D

Social Reactions Questionnaire

(Ullman, 2000)

Considering the person or people in whom you confided about the experiences mentioned above, please answer the following questions using the following scale:

0	1	2	3	4
Never	Rarely	Sometimes	Frequently	Always

Section 1: Emotional Support/Belief

1. How often have they told you that you were not to blame? _____
2. How often have they told you that you didn't do anything wrong? _____
3. How often have they told you it wasn't your fault? _____
4. How often have they reassured you that you are a good person? _____
5. How often have they held you or told you that you were loved? _____
6. How often have they comfort you by telling you it would be alright or by holding you?

7. How often have they spent time with you? _____
8. How often have they listened to your feelings? _____
9. How often have they showed understanding of your experience? _____
10. How often have they reframed the experience as a clear case of victimization? _____
11. How often have they seen your side of things and did not make judgments? _____
12. How often were they able to really accept your account of your experience? _____
13. How often have they told you he/she felt sorry for you? _____
14. How often have they believed your account of what happened? _____
15. How often have they seemed to understand how you were feeling? _____

Section 2: Treatment

1. How often have they acted as if you were damaged goods or somehow different now?

2. How often have they pulled away from you? _____
3. How often have they treated you differently in some way than before you told him/her that made you uncomfortable? _____
4. How often have they avoided talking to you or spending time with you? _____
5. How often have they focused on his/her own needs and neglected yours? _____
6. How often have they said he/she feels tainted by this experience? _____

Section 3: Distraction

1. How often have they told you to stop talking about it? _____
2. How often have they told you to stop thinking about it? _____
3. How often have they tried to discourage you to stop talking about the experience? _____
4. How often have they told you to go on with your life? _____
5. How often have they encouraged you to keep the experience a secret? _____
6. How often have they distracted you with other things? _____

Section 4: Control

1. How often have they made decisions or did things for you? _____
2. How often have they tried to take control of what you did/decisions that you made? _____
3. How often have they said he/she understood how you felt when he/she really didn't? _____
4. How often have they told others about your experience without your permission? _____
5. How often have they treated as if you were a child or somehow incompetent? _____
6. How often have they minimized the importance or seriousness of your experience? _____

7. How often have they made you feel like you didn't know how to take care of yourself?

Section 5: Tangible Aid / Information Support

1. How often have they helped you get medical care? _____

2. How often have they provided information and discussed options? _____

3. How often have they helped you get information of any kind about coping with the experience? _____

4. How often have they taken you to the police? _____

5. How often have they encouraged you to seek counseling? _____

Section 6: Victim Blame

1. How often have they told you that you could have done more to prevent this experience from occurring? _____

2. How often have they told you that you were irresponsible or not cautious enough? _____

3. How often have they told you that you were to blame or shameful because of this experience?

Section 7: Self-centricity

1. How often have they expressed so much anger at the perpetrator that you had to calm him/her down? _____

2. How often have they told you that he/she felt personally wronged by your experience?

3. How often have they been so upset that he/she needed reassurance from you? _____

4. How often have they wanted to seek revenge on the perpetrator? _____

APPENDIX E

Symptom Checklist

(Briere and Runtz, 1989)

How often have you experienced each of the following in the last two months?

0 = Never 1= Rarely 2= Sometimes 3 = Often

1. Headaches	0 1 2 3
2. Insomnia (trouble getting to sleep)	0 1 2 3
3. Weight loss (without dieting)	0 1 2 3
4. Stomach problems	0 1 2 3
5. Sexual problems	0 1 2 3
6. Feeling isolated from others	0 1 2 3
7. "Flashbacks" (sudden, vivid, distracting memories)	0 1 2 3
8. Restless sleep	0 1 2 3
9. Low sex drive	0 1 2 3
10. Anxiety attacks	0 1 2 3
11. Sexual overactivity	0 1 2 3
12. Loneliness	0 1 2 3
13. Nightmares	0 1 2 3
14. "Spacing out" (going away in your mind)	0 1 2 3
15. Sadness	0 1 2 3
16. Dizziness	0 1 2 3
17. Not feeling satisfied with your sex life	0 1 2 3
18. Trouble controlling your temper	0 1 2 3
19. Waking up early in the morning and can't get back to sleep	0 1 2 3
20. Uncontrollable crying	0 1 2 3
21. Fear of men	0 1 2 3
22. Not feeling rested in the morning	0 1 2 3
23. Having sex that you didn't enjoy	0 1 2 3
24. Trouble getting along with others	0 1 2 3

25. Memory problems	0 1 2 3
26. Desire to physically hurt yourself	0 1 2 3
27. Fear of women	0 1 2 3
28. Waking up in the middle of the night	0 1 2 3
29. Bad thoughts or feelings during sex	0 1 2 3
30. Passing out	0 1 2 3
31. Feeling that things are "unreal"	0 1 2 3
32. Unnecessary or over-frequent washing	0 1 2 3
33. Feelings of inferiority	0 1 2 3
34. Feeling tense all the time	0 1 2 3
35. Being confused about your sexual feelings	0 1 2 3
36. Desire to physically hurt others	0 1 2 3
37. Feelings of guilt	0 1 2 3
38. Feelings that you are not always in your body	0 1 2 3
39. Having trouble breathing	0 1 2 3
40. Sexual feelings when you shouldn't have them	0 1 2 3

Note: Items 1,4,10,16,21,27,32,34,39 go into Anxiety subscale
Items 2,3,9,15,19,20,26,33,37 go into Depression subscale

VITA

HOLLY ELIZABETH HOPSON

- Personal Data: Date of Birth: September 5, 1980
- Place of Birth: Kingsport, Tennessee
-
- Education: Dobyns-Bennett High School, Kingsport, Tennessee
- B.S. Psychology, Legal Studies minor, East Tennessee State
 University, Johnson City, Tennessee 2003
- M.A. Psychology, East Tennessee State University, Johnson City,
 Tennessee 2010
- Lifetime member ETSU chapter of Psi Chi, The National Honor
 Society for Psychology
-
- Professional Experience: Tuition Scholar, East Tennessee State University, Department of
 Psychology, 2005- 2007
- President, Pinnacle Ranch, LLC, Kingsport, Tennessee, 2008-
 present
- Adjunct Faculty, Northeast State Community College, Blountville,
 Tennessee, 2009- present