Childhood Sexual Abuse History:

Attachment, Mattering, and Coping Among Young Adults

by

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ABSTRACT

The present study examined whether a history of childhood sexual abuse would be related to attachment to mother, to father, and to friends, mattering to parents and to friends, and coping behaviors. In addition, whether use of force, duration of abuse, and severity of abuse were related to perceived negative impact of childhood sexual abuse was examined. Gender differences among survivors were also investigated. Specifically, from the initial sample of 258 young adults, 186 who met the age requirement were included in the tests of the hypotheses. All participants were between the ages of 18 and 25. Compared to those with no history of childhood sexual abuse (n = 109), survivors (n = 77) reported lower attachment to father and less mattering to parents. There were no differences in attachment and mattering to friends or in emotion-focused and problem-focused coping. When gender differences were examined among survivors, females reported greater use of problem-focused coping and perceiving their childhood sexual abuse experiences as more negative than did the male survivors. There were no differences among male and female survivors of childhood sexual abuse on emotion-focused coping. Force and severity, but not duration, were linked to more negative perceptions of the childhood sexual abuse. Attachment to mother emerged as a key variable in that attachment to mother was positively related to attachment to friends, mattering to friends, and the use of problem-focused coping. Stronger attachment to mother and attachment to father, but not a history of childhood sexual abuse, were related to more perceived mattering to parents. These results highlight the importance of attachment to caregivers in developing

peer attachment and a sense of mattering to friends, problem-focused coping skills, and perceiving childhood sexual abuse as having a less negative impact on their lives. Clinical and research implications and suggestions for future directions are discussed.

DEDICATION

Dedicated to survivors of childhood sexual abuse and at-risk youth who are resilient in spite of the traumas they have experienced.

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The Problem in Perspective

Studies examining the effects of childhood sexual abuse have become more prominent in the literature during the last few decades. Research has found that survivors of childhood sexual abuse experience numerous negative psychological, physical, and social consequences (e.g., Allen, 2005; Cavanaugh, 2002; Stuewig & McClosky, 2005). One of the first empirical reviews of the effects of childhood sexual abuse was conducted by Alter-Reid, Gribbs, Lachenmeyer, Signal, and Massoth in 1986. Alter-Reid's research team found that survivors of childhood sexual abuse experience negative consequences related to their abuse, such as poor self-esteem, depression, at-risk behaviors (e.g., sexual promiscuity, running away from home, truancy), and interpersonal problems.

In 1993, Green examined both the immediate and long-term effects of childhood sexual abuse. Green found that the immediate aversive effects of childhood sexual abuse included anxiety disorders, dissociation and hysterical symptoms, depression, low self-esteem, and sexual problems. In addition to experiencing depression, anxiety, and low self-esteem as long-term negative consequences of childhood sexual abuse, survivors also engaged in self-harming behaviors (e.g., suicide, alcohol and drug use).

Paolucci, Genius, and Violato's (2001) meta-analysis on the effects of child sexual abuse found that a history of child sexual abuse was correlated with Post Traumatic Stress Disorder, depression, suicide, sexual promiscuity, and

academic achievement problems. Several studies have reported that both male and female child sexual abuse survivors engage in effective coping strategies. Researchers have found that male survivors engage in externalizing behaviors (e.g., aggression, truancy), while female survivors utilize internalizing coping strategies (e.g., depression, shame) (e.g., Feiring, Taska, & Lewis, 1999; Ullman & Filipas, 2005). These meta-analyses show that gaining empirically based knowledge of childhood sexual abuse is crucial in understanding how to recognize and treat better those who have experienced childhood sexual abuse.

Research has found that a history of childhood sexual abuse is related to interpersonal problems (e.g., Bergen et al., 2004; Dube et al., 2005; Nurcombe, 2000). In addition to a history of childhood sexual abuse, attachment to mother and father also affects the development of adaptive intra-and-interpersonal relationships (Bowlby, 1969). Numerous studies have found that secure attachment to parents is correlated with positive outcomes, such as prosocial behavior, higher levels of self-esteem, and positive coping strategies (Bowlby; Granot & Mayseless, 2001; Sroufe, Egeland, & Kreutzer, 1990). The literature also shows that healthy peer relationships is related to less psychological or school-related problems, less loneliness, and being confident that one will be accepted by his or her peers (e.g., Bagwell, Newcomb, Bukowski, 1998; Hay & Ashman, 2003). Although the research has found that both child sexual abuse and attachment to parents is related to intra-and-interpersonal development, there is dearth of literature examining the effects of both of these factors on psychological and social development outcomes among survivors. Since both of these variables

potentially impact the development of young people significantly, the purpose of this study is to assess whether a history of childhood sexual abuse and strength of parental attachment are related to older adolescents' perceptions of peer attachment, use of coping strategies, and sense of mattering to others. While most childhood sexual abuse studies have focused on women (e.g., Banyard, Williams, & Siegel, 2004; Holmes, 1998), this study will assess these variables among both men and women.

Childhood Sexual Abuse

Prevalence, Definitions, and Risk Factors of Childhood Sexual Abuse

Child abuse is a serious public health problem in the United States. Sexual abuse occurs in every culture, ethnicity, socioeconomic class, religion, and education level in the U.S. (National Child Abuse Statistics, 2005). There are roughly 3 million child maltreatment reports made yearly; however, experts believe the actual number of child abuse and neglect incidents are 3 times greater than what is reported annually (National Child Abuse Statistics). In Arizona, over 70,000 suspected cases of child abuse are reported to Child Protective Services (CPS) each year (Arizona Department of Economic Security, 2004). In America, between 35% and 62% of women and one in four men are sexually abused before they reach 18 years of age (Freeman & Morris, 2001; Weiner & Robinson Kurpius, 1995; Whetsell-Mitchell, 1995). In the United States each year, roughly 100,000 children are survivors of sexual abuse (U.S. Department of Health and Human Services, 2001). Of the sexual assault cases reported to American law enforcement agencies, one of every six victims was under six years of age

(National Child Abuse Statistics). "Among rape victims less than 12 years of age, 90% of the children knew the offender" (National Child Abuse Statistics). In fact, three-quarters of sexual abuse perpetrators are family friends or neighbors (Child Maltreatment, 2004).

Mental health professionals are mandated by law to report child physical, emotional, and sexual abuse, as well as neglect. Both federal and state laws define child abuse and neglect. The Child Abuse Prevention and Treatment Act (CAPTA) provides states with a minimum child abuse and neglect definition that must be incorporated in states' statutes (Definitions of Child Abuse and Neglect, 2005). CAPTA, 42 U.S.C.A § 5106g(2), defines child abuse and neglect as:

> Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk or serious harm (Definitions of Child Abuse and Neglect).

Since each state has variations in their laws, mandatory reporters of child abuse and neglect should review their state's statutes for child abuse and neglect definitions, reporting requirements, and reporting procedures.

For example, Arizona defines sexual abuse, sexual conduct with a minor, sexual assault, and molestation of a child under Arizona Revised Statute (ARS) §8-201(2) (Arizona Department of Economic Security, 2006). Sexual abuse, as defined in ARS §13-1404, occurs when "a person commits sexual abuse by intentionally or knowingly engaging in sexual contact with any person fifteen or more years of age without consent of that person or with any person who is under

fifteen years of age…(Arizona Department of Economic Security). Arizona defines sexual conduct with a minor, ARS §13-1405, as occurring when "a person commits sexual conduct with a minor by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person who is under eighteen years of age" (Arizona Department of Economic Security). In addition, sexual assault, ARS §13-1406, occurs when "a person commits sexual assault by intentionally or knowingly engaging in sexual intercourse or oral sexual contact with any person without consent of such person" (Arizona Department of Economic Security). ARS §13-1410 defines molestation of a child as "a person commits molestation of a child by intentionally or knowingly engaging in or causing a person to engage in sexual contact…with a child under fifteen years of age" (Arizona Department of Economic Security).

Just as state laws have varying definitions of sexual abuse, researchers report discrepant prevalence rates of childhood sexual abuse due to differing definitions and methodological approaches. Participant eligibility for a study is often determined by how the childhood sexual abuse is defined. A prominent definitional issue is whether or not the sexual abuse involves contact (Priebe & Svedin, 2008; Salter, 1992). Contact sexual abuse includes some type of touching, such as penetration or fondling, between the perpetrator and survivor (Beasley, 1997; Priebe & Goran Svedin). Children who experience non-contact sexual abuse are exploited through pornography or exhibitionism (Beasley; Priebe & Goran Svedin). Prevalence rates of childhood sexual abuse increase when non-

contact cases are included in studies, while prevalence rates decrease in studies whose definition of sexual abuse is restricted to contact abuse (Salter).

Another definitional problem involves the age difference between the perpetrator and survivor (Beasley, 1997). Researchers have defined the age of the perpetrator as being at least 18 years of age or ranging from 2 to 10 years older than the survivor, while the age range of survivors in studies range from below the age of 12 and up to the age 18 (Beasley; Finkelhor, 1993; Salter, 1992; Whitaker et al., 2008). These studies obtained varying sexual abuse prevalence statistics by excluding participants who are not in the designated age range or who had experienced sexual assault from peers (Beasley).

In Beasley's (1997) study, she clearly defined her study population based on the age of both the survivor and perpetrator, type and force of sexual abuse, and the survivor's relationship to the perpetrator. She interviewed 60 adolescent females ranging from 12 to 17 years of age who were seeking sexual abuse treatment at a community clinic. Beasley assessed differences between adolescents who had either been raped or sexually abused on self-report measures of depression, anxiety, negative acting out behaviors, and family environment, as well as self, social, and physical self-concepts. The survivors reported more negative acting out behaviors after the sexual abuse or rape, and experienced less physically related self-esteem than social self-esteem. Beasley's study also found that abuse-specific variables (i.e. penetration, force, duration/frequency) were not significant predictors of the study's outcome variables. This finding suggests that while these sexual abuse specific related variables may affect prevalence

statistics, they may not necessarily be confounding variables with respect to outcome variables for survivors who are now teenagers.

Many factors, such as family structure, interpersonal relationships, community dynamics, and societal influences, affect the incidence of child sexual abuse. Although children are never at fault for the child sexual abuse they may experience, there are certain individual characteristics of a child that may increase their risk of being abused. Risk factors contribute to sexual abuse; they do not cause sexual abuse. Girls are more vulnerable than boys to being sexually abused, especially during pre-adolescence and adolescence (Finkelhor, 1993). Also, children living with a stepfather in the home are more at risk for sexual abuse (Finkelhor; Weiner & Robinson Kurpius, 1995; Whetsell-Mitchell, 1995). Risk factors for rape include early puberty for girls, being sexually active, early dating, and poor peer relationships (Vicary, Klingman, & Harkness, 1995). Additional factors that place children at risk for being sexually abused are social isolation, parents' lack of education about raising children, parents who have a history of abuse, socioeconomic disadvantages (poverty, unemployment), family violence, substance abuse, non-biological parents who are young and single, poor communication, parental mental health conditions, and violence in the community (National Center for Injury Prevention and Control, 2006). Not only is it important for mental health professionals to be aware of the risk factors of sexual abuse, they must also be knowledgeable of the negative effects of childhood sexual abuse.

Effects of Childhood Sexual Abuse

Children may experience negative physical, psychological, and behavioral consequences as a result of being sexually abused. Children experience and respond to sexual abuse differently due to a variety of reasons. Factors that may affect the consequences of sexual abuse in children are the child's age when the abuse occurred, duration, frequency, and severity of abuse, and the relationship between the victim and the abuser (Long-Term Consequences, 2006; Weiner & Robinson Kurpius, 1995). However, Beasley (1997) found that penetration, the use of force, and the duration and frequency of sexual abuse were not related to her outcome variables among her sample of teenage sexual abuse survivors. To provide effective prevention and treatment services to survivors, mental health professionals must be knowledgeable about both the short-and long-term effects of childhood sexual abuse.

Studies examining the effects of childhood sexual abuse have become more prevalent in the literature during the past few decades. Alter-Reid et al. (1986) completed one of the first empirical reviews of intra-and-extrafamiliar childhood sexual abuse with a focus on incest; they concluded there was a dearth of studies on childhood sexual abuse. These researchers analyzed 15 articles that included both child survivor and adult retrospective studies. Researchers assessed studies that utilized clinical populations as well as had study designs with comparison control groups. Alter-Reid's research team found that child and adolescent incest survivors often reported experiencing negative consequences that included poor self-esteem, guilt, fear, depression, anger, distrust, poor interpersonal skills, and

role confusion. Survivors also demonstrated at-risk behaviors, such as running away, sexual promiscuity, and truancy. Adult survivors of incest reported symptoms of fear, low self-esteem, depression, sexual dysfunction, and interpersonal difficulties. Alter-Reid and colleagues purported that incest survivors were overrepresented in prostitute, drug user, and adult abuser populations. Identified family risk factors for incest were having a mother with a physical or mental impairment, being an older daughter who engaged in a maternal family role, or a family dominated by the father. These authors argued that sexual abuse research should be more rigorous and should use valid measures, comparison groups, and large sample sizes.

Browne and Finkelhor (1987) conducted a historical review of the sexual abuse literature and focused on the short-term effects of childhood sexual abuse. Child sexual abuse was defined as forced sexual acts on a child by a perpetrator who was at least five years older than the female survivor. Browne and Finkelhor reviewed 26 studies and found that several externalizing and internalizing behaviors were present among survivors within six months to two years following self-disclosure of the sexual abuse. Browne and Finkelhor encouraged professionals to interpret research results with caution because these studies had methodological concerns (i.e. lacked comparison groups and objective measures). These researchers organized the effects of childhood sexual abuse in four categories: 1) Emotional reactions and self-perceptions; 2) physical consequences and somatic complaints; 3) inappropriate sexual behavior; and 4) social functioning. Compared to non-abused children, survivors reported greater

difficulties managing social relationships and had lower self-esteem. Survivors demonstrated negative emotional reactions and self-perceptions in response to their sexual abuse. Internalized symptoms included depression, fear, anger, shame, and guilt. Problematic externalizing behaviors reported by survivors were aggression, running away, obtaining poor grades, and truancy. Browne and Finkelhor found that the most common physical consequences and somatic complaints from sexual abuse were sleep disturbances, anxiety, and poor eating patterns. Survivors also often displayed inappropriate sexual behaviors. Young children experienced excessive sexual curiosity and masturbation, and adolescents engaged in sexual promiscuity. Poor social functioning was related to a history of sexual abuse; survivors had difficulties functioning at home and in school. Overall, Browne and Finkelhor found that a history of childhood sexual abuse was related to negative intra-and-interpersonal outcomes.

In 1993, Kendall-Tackett, Williams, and Finkelhor reported their analysis of 45 childhood sexual abuse studies. Inclusion criteria for reviewed studies required that studies had been completed in the previous five years and had a comparison group, sexual abuse had occurred when the survivor was under the age of 18, and only examined intra-and-extrafamilial sexual abuse cases. When compared to non-abused children, survivors had greater difficulties with Post Traumatic Stress Disorder (PTSD) with symptoms that included hypervigilance, nightmares, fear, and flashbacks. Survivors had higher levels of depression (e.g., suicide, feeling down), aggression, somatic complaints, inappropriate sexual behavior (e.g., promiscuity), at-risk behaviors (e.g., running away, substance use),

problems with school and learning, and low self-esteem. Reviewing intervening variables in 25 of the 45 studies, Kendall-Tackett et al. found that a child's age when the abuse occurred, age at assessment, and the survivor's sex had discrepant results across studies. These sexual abuse variables were not consistently predictive of symptomatology. However, a high frequency of sexual abuse, penetration, a close relationship between the survivor and perpetrator, duration of abuse, and coercion were predictive of increased symptoms in sexual abuse survivors. While 20% to 30% of sexually abused children reported the aforementioned symptoms, up to 50% of sexually abused children were asymptomatic; however, 43% of the variance in sexualized behavior, 35% of the variance in depression, and 15% of the variance in anxiety were accounted for by a history of child sexual abuse.

Green (1993) examined both the immediate and long-term effects of childhood sexual abuse among child and adolescent survivors. He categorized the immediate effects of child sexual abuse in four areas: 1) Anxiety disorders; 2) dissociation and hysterical symptoms; 3) depression and low-esteem; and 4) sexual disturbances. Participants reported anxiety symptoms including sleep disturbances, nightmares, fear, somatic complaints, and PTSD. Survivors experienced dissociative and hysterical symptoms, such as exorbitant levels of fantasizing or daydreaming, being in a trance-like state, and having an imaginary friend. Children and adolescent survivors of sexual abuse frequently reported feeling depressed and having low self-esteem. Young survivors also manifested problematic sexualized behaviors including sexual aggression, excessive

masturbation, sexualized play, and promiscuity. The long-term effects of childhood sexual abuse were symptoms of anxiety, depression, low self-esteem, and sexual dysfunction (e.g., lack of sex drive, avoidance). Survivors also engaged in self-harming behaviors, such as suicide and drug and alcohol use. Green stated that compared to non-abused women, sexual abuse survivors represented a greater proportion of women diagnosed with dissociative identity disorder (DID) and bipolar disorder. Furthermore, survivors of childhood sexual abuse were at greater risk for revictimization later in life (e.g., rape, domestic violence). Green made a valuable contribution to the literature by more specifically outlining the short-and-long-term effects of childhood sexual abuse.

In 2001, Paolucci, Genius, and Violato conducted a meta-analysis on certain effects of child sexual abuse, which they defined as any unwanted sexual act ranging from genital fondling to penetration. They reviewed 37 studies published between 1981 and 1995. Paolucci and colleagues were interested in six outcome variables: PTSD; depression; suicide; sexual promiscuity; victim-perpetrator cycle; and poor academic performance. By law, the survivor was considered to be a child, and the perpetrator was in a position of power relative to that of the survivor. For inclusion in their meta-analysis, studies had to include a contrast group of participants who had not experienced child sexual abuse, to have used psychometrically sound measures, and to have a sample size of 12 or more. Their meta-analysis suggested that child sexual abuse was positively related to: 1) PTSD (i.e. re-experiencing the trauma, numbing, avoidance of trauma related stimuli, anxiety, sleep disturbances, hyper-vigilance, dissociative states,

concentration difficulties, and diminished interest in activities that were previously viewed as enjoyable); 2) depression (i.e. despondent mood and loss of interest or pleasure, irritability, sadness, appetite or weight changes, feelings of guilt or worthlessness, sleep problems, and difficulty thinking, concentrating, or making decisions); 3) suicide (i.e. reoccurring thoughts of death or suicide plans, gestures, or attempts); 4) sexual promiscuity (i.e. early sexual involvement or prostitution); and 5) academic achievement (i.e. achievement or intelligence scores and teacher or self-ratings of learning). A history of childhood sexual abuse increased PTSD by 20%, depression by 21%, suicide outcome by 21%, sexual promiscuity by 14%, victim-perpetrator cycle by 8%, and academic performance by 10%. Similar to some of Beasley's (1997) results, Paolucci and colleagues found that the sexual abuse factors of survivors' gender, socioeconomic status (SES), age when abuse occurred, type of sexual abuse, the survivor's relationship to the perpetrator, and the number of sexual abuse incidents did not mediate the effect of childhood sexual abuse on outcome variables.

Additional studies conducted more recently corroborate the aversive effects of childhood sexual abuse. A history of sexual abuse has been linked to negative health outcomes (Bonomi et al., 2009), such as suicide (Allen, 2005; Dube et al., 2005; Joiner et al., 2007; Jumper, 1995), eating disorders (Allen; Favaro, Ferrera, & Santonastaso, 2003; Preti et al., 2006), and self-mutilation (Cavanaugh, 2002). Survivors often receive the mental health diagnoses of anxiety disorders (e.g., PTSD) (Fergusson, Boden, & Horwood, 2008a; Fergusson, Horwood, & Lynskey,

1996), depression (Bonomi et al.; Duncan, 2004; Schilling, Aseltine, & Gore, 2007; Stuewig & McClosky, 2005), bipolar disorder (Leverich, et al., 2002), phobias (as cited in Lundqvist, Hansson, & Goran Svedin, 2004), dissociative disorders (Allen, 2005), and obsessive-compulsive disorder (as cited in Lundqvist et al.). People with a history of child sexual abuse are more likely than those not abused to engage in at-risk behaviors. Survivors often have drug or alcohol problems (Allen; Bergen et al., 2004; Fergusson, Boden, & Horwood, 2008b; Whetsell-Mitchell, 1995), engage in aggressive or delinquent behaviors (Leeb, Barker, & Strine, 2007; Smith & Thornberry, 1995), and have unsafe and/or promiscuous sexual behaviors (Paolucci et al., 2001; Senn, Carey, & Vanable, 2008). Childhood sexual abuse has also been associated with low self-esteem (Nurcombe, 2000; Tubman et al., 2004), feelings of shame (Feiring & Tasking, 2005), self-blame (Filipas & Ullman, 2006; Peters & Range, 1996), fear (Davis, Petretic-Jackson, & Ting, 2001), difficulties with school adjustment (Boden, Horwood, & Fergusson, 2007; Duncan; Gibby-Smith, 1995), problems with peer, social, and intimate relationships (Bergen et al., 2004; Dube et al.; Nurcombe; Tubman et al.), poor coping skills (Bergen et al., Duncan; Filipas & Ullman), insecure and anxious attachment styles in interpersonal relationships (Bacon & Richardson, 2001; Filipas & Ullman; George, 1996; Lewis et al., 2003), and academic struggles (e.g., lower completion rates and lower grade point average) (Boden et al.; Duncan; Gibby-Smith). Murthi and Espelage (2005) found that survivors of childhood sexual abuse experienced a “loss of optimism, (e.g., loss in

ability to dream about the future), loss of self (e.g., feel lost and helpless), and loss of childhood (e.g., grew up too fast)" (pp. 1227-1228).

Summary of the Impact of Childhood Sexual Abuse

Meta-analyses and individual research studies have found that a history of childhood sexual abuse is related to negative immediate and long-term psychological, social, and physical effects (e.g., Green, 1993). Survivors of childhood sexual abuse experience low self-esteem, depression, and anxiety (e.g., Fergusson et al., 2008a; Nurcombe, 2000; Stuewig & McClosky, 2005; Tubman et al., 2004). People who experience sexual abuse may have difficulties interacting with others or finishing school (e.g., Bacon & Richardson, 2001; Boden et al., 2007; Duncan, 2000; Gibby-Smith, 1995). Survivors may also have health problems or engage in self-harm behaviors (e.g., Bergen et al., 2004; Favaro et al., 2003). A history of sexual abuse can result in a myriad of symptomatologies. Mental health professionals working with survivors need to be knowledgeable about diagnosing and treating the negative outcome associated with childhood sexual abuse.

Gender Differences among Childhood Sexual Abuse Survivors

Studies have reported gender differences for disclosure and effects of childhood sexual abuse. Women are more frequently survivors in sexual abuse studies, thus more is known about the effects of childhood sexual abuse for women than for men (Banyard, Williams, & Siegel, 2004; Holmes, 1998). While researchers confirm that both men and women experience negative effects (i.e. mental health problems, sexual difficulties, and interpersonal struggles) from

experiencing sexual abuse as a child (Duncan & Williams, 1998; Miller & Lisak, 1999; Paolucci et al., 2001), they still call for more research examining sexual abuse related outcomes for men and women.

Priebe and Svedin (2008) conducted a study with 4,339 high school seniors. Of these seniors, 1,505 females (65%) and 457 males (23%) reported a history of sexual abuse. The disclosure rate was 81% for the females and 69% among the males. The female and male students most often disclosed their sexual abuse experiences to a friend similar in age. Few of these students had disclosed their sexual abuse to a professional or the authorities. Priebe and Svedin found that the female students were less likely to disclose their sexual abuse if contact abuse occurred, a family member was the perpetrator, the abuse happened once, and their parents were viewed as uncaring. Males were less likely to tell someone about their sexual abuse if they lived with both parents; they also did not disclose whether or not they viewed their parents as caring/uncaring or overprotective/not overprotective.

Research has suggested that men and women may experience differential effects of childhood sexual abuse because most perpetrators are men (Duncan & Williams, 1998). Thus, men are more likely than women to experience sexual abuse by someone who is the same sex. Duncan and Williams suggested that men who are sexually abused by other men may respond to their abuse by being physically forceful in intimate relationships or by becoming more understanding of women's lack of power in relationships. Male survivors may also be less likely than women to report this abuse due to the stigma associated with male-on-male

sexual interactions (Holmes, Offen, & Waller, 1997). Researchers have also noted that a majority of cases where women sexually abuse men may be underreported (e.g., Dhaliwal et al., 1996). Males may be less likely to view sexual assault by female perpetrators as abuse (Kinnear, 2007) and may consider their sexual interactions as part of normal socialization for men to have early sexual interactions with women (Banyard et al., 2004).

Significant gender differences in the effects of childhood sexual abuse on men and women have been reported. For example, Banyard and colleagues (2004) found that female survivors of childhood sexual abuse, as compared to male survivors, had higher levels of anxiety and depression. Martin, Bergen, Richardson, Roeger, and Allison (2004) reported that boys and girls' level of distress was related to suicidal ideas and plans. They found that 55% of the boys (n = 15) and 29% of girls (n = 17) who were sexual abuse survivors in their study had attempted suicide. Feiring, Taska, and Lewis (1999) reported that among a sample of 169 children (n = 96) and adolescents (n = 73), girls with a sexual abuse history had higher levels of hyperarousal, instructive thinking, sexual anxiety, feelings of vulnerability, perceptions of the world as dangerous, and sexual eroticism than boys. Male childhood sexual abuse survivors are less sexually inhibited, less sexually anxious, more likely to engage in unprotected sex, and have greater numbers of sexual partners than are female survivors (Friedrich et al., 1992; Oliver & Hyde, 1993; Rotheram-Borus et al., 1996). Furthermore, women respond to childhood sexual abuse with more internalizing and less externalizing coping strategies, while male survivors demonstrate more

externalizing than internalizing behaviors (Bergen et al., 2004; Burke, Loeber, & Birmaher, 2002).

General Summary of Childhood Sexual Abuse

The high prevalence of sexual abuse in the U.S. is concerning and demands the attention of mental health professionals. It is highly likely that counseling psychologists will work with, either through research or clinical experience, survivors of childhood sexual abuse. Reviews of the literature categorize sexual abuse symptoms and effects by: 1) Internalized symptoms (i.e. depression, anxiety); 2) externalized or at-risk behaviors (e.g., suicide, sexual promiscuity, alcohol and drug use, truancy); and 3) self-concept (i.e. self-esteem) and interpersonal relationship difficulties. Research also suggests that intervening variables, such as frequency and duration of abuse, type of perpetrator, and age of abuse, may or may not affect outcome variables. Men and women may also process and respond to child sexual abuse differently.

The literature demonstrates the devastating short-and-long term effects of childhood sexual abuse. Childhood sexual abuse negatively impacts survivors' physical and mental health, as well as their ability to feel positive or connect healthfully with themselves and others. A history of sexual abuse is not the only factor that has a significant impact on young people's development. Research has also found that secure attachments or mother, father, and peers is related to positive intra-and-interpersonal outcomes (e.g., Bowlby, 1969).

Child Development through Early Adulthood

Erikson's Stages of Psychosocial Development (1959)

Erikson believed that the "self" started to develop within the first few months of life and that "at birth the baby leaves the chemical exchange of the womb for the social exchange system of his society, where his gradually increasing capacities meet the opportunities and limitations of his culture" (p. 92). Erikson (1959) proposed that people work through eight crises of development from infancy through older adulthood (only the first six stages will be discussed for the purpose of this study).

The first stage of Erikson's (1959, 1968) developmental model is trust versus mistrust, which occurs from birth through the first year of life. Erikson (1968) defined trust as "an essential trustfulness of others as well as a fundamental sense of one's own trustworthiness" (p. 96). During the first year of life, an infant begins to understand the difference between self and other as he or she start to form a relationship with his or her caretaker(s). Erikson states that learning about mistrust is an important part of development; however, if a child is more mistrustful than trustful, this will result in the negative outcomes of low self-esteem, lack of confidence, withdrawn behavior, and suspiciousness of others.

The second stage, autonomy versus shame and doubt, lasts from one to three years of age (Erikson, 1959). Experiencing failure and anxiety as a child begins to talk, walk, and experience separation from caregivers is salient during this developmental period. A child's self-esteem is affected by the manner in which

caregivers respond to the child's mastery of tasks. Positive aspects of this stage are children's ability to gain some independence from their parents. However, children experience the feeling of shame as result of self-doubt. Children in this stage are self-oriented, are guided by external versus internal controls, and must learn to let go of control.

The initiative versus guilt stage of development occurs between ages four to six years (Erikson, 1959). During this period, children make advances in their language development, thought processes, motor skills, and creativity. Most importantly, children begin to identify with their parents. Erikson stated that a child "wants to be like his parents, who to him appear very powerful and very beautiful, although quite unreasonably dangerous" (p. 74). Children have difficulties taking personal responsibility for their actions, and one of their main goals is to avoid punishment. Experiencing sexual abuse during this period negatively impacts the developmental process (Whetsell-Mitchell, 1995). Indicators that a child is being sexually abused during this time include demonstrating regressions in developmental behaviors (e.g., excessive bed wetting, rocking), having nightmares, engaging in sexually seductive behavior, demonstrating age-inappropriate sexual knowledge, excessively masturbating, developing phobias, having prominent changes in behavior (e.g., becoming aggressive or shy), or placing objects in the vagina or anus. If any of these symptoms are present, it is recommended that a child meet and work with a mental health professional (Whetsell-Mitchell).

From age six to puberty, children enter the industry versus inferiority stage (Erikson, 1959). Children become increasingly aware of their thought and feeling processes and begin to recognize that both they and others can express positive and negative traits. If a child experiences abuse during this period of development, he or she may have difficulties maintaining friendships. The child may also feel confused, shameful, or guilty about the abuse (Cole & Putnam, 1992). If children's boundaries are violated through sexual abuse, they will have difficulties developing their own boundaries. If abuse occurs from a caretaker, children will struggle to learn self-control strategies as their caretakers lack self-control themselves. Signs that a child may be coping with sexual abuse during this developmental stage are feelings of anxiety or depression, sleep disturbances, running away from home, truancy, changes in eating patterns, earning poor grades, abrupt behavioral changes, self-mutilation, and exhibiting inappropriate sexual behaviors (e.g., sexual aggression) (Whetsell-Mitchell, 1995). Children in this development stage often disclose their sexual abuse experiences to an adult (Kogan, 2004).

Stage five, identity and repudiation versus identity diffusion, occurs during adolescence (Erikson, 1959). The main task of this stage is for the adolescent to gain a sense of a complete self through the infusion of his or her social roles. The adolescent will experience identity diffusion if he or she is not able to develop an integrated self. The process of solidifying an adolescent's identity may become more difficult if the person is questioning his or her sexual orientation, is from an ethnic minority culture, is overly emotionally dependent on a caregiver, or has

experienced abuse. Major developmental tasks during this period are gaining a greater understanding of one's sex-roles, gaining autonomy from caregivers, choosing a college major or career, and internalizing personal values (Whetsell-Mitchell, 1995). If an adolescent is being sexually abused during this developmental phase and is engaging in dissociative or denial coping strategies, he or she will have difficulties integrating aspects of self and forming romantic relationships (Whetsell-Mitchell). Indicators of sexual abuse during this period are delinquent behavior, being anxious or depressed, socially withdrawn, running away from home, early pregnancy or sexual promiscuity, drug and alcohol use, suicide attempts, and truancy (Whetsell-Mitchell). An adolescent is more likely to disclose their sexual abuse to a peer than to a parent or professional (Kogan, 2004).

The last stage discussed here, intimacy versus isolation, occurs in early adulthood (Erikson, 1959). This stage focuses on a young adult's ability to sustain a meaningful commitment to another person, such as through being a spouse, parent, or partner. While some researchers disagree (as cited in Horst, 1995), Erikson believed that a woman does not have her own identity through childhood and adolescence until she "attracts a husband;" her identity becomes defined through her husband (Whetsell-Mitchell, 1995, p. 149). However, research does show that survivors of sexual abuse have difficulties maintaining healthy, trusting relationships (Davis et al., 2001). Problems with intimate relationships are reflected in the higher divorce rates among sexual abuse survivors relative to adults without a history of sexual abuse (Krahe, 2000).

Erikson's stages provide mental health professionals with guidelines for expected developmental milestones throughout the lifespan. Research shows that secure attachment to parents and peers assists with completing developmental stages in an adaptive manner (e.g., Bowlby, 1969).

Attachment Theory Related to Child and Adolescent Development

In 1969, Bowlby developed the Attachment Theory that focused on the importance of the relationship between a caregiver and child. Attachment Theory, however, does not examine the child's behavior toward the caregiver. Bowlby asserted that a child's development of an attachment toward a caregiver is a normal aspect of social functioning that starts at infancy. Infants are dependent on their caregiver, and infants' sense of dependency occurs well before they are attached to their caregiver (Bowlby). A child who has an attachment to a caregiver is not viewed as maladjusted; a child cannot be "too attached" according to Bowlby's theory.

There are four main attachment styles that children can develop: 1) Secure; 2) Avoidant; 3) Ambivalent; and 4) Disorganized (Bowlby 1969). Children with secure attachment styles have relationships with their caregivers that are stable, supportive, trusting, and warm (Bowlby; Granot & Mayseless, 2001). The caregiver demonstrates that the child is important and valued and approaches conflict with the child in a positive manner by providing reliable and educational interventions to the child (Bowlby; Granot & Mayseless). Secure children have situation-appropriate behavior and are able to act in a spontaneous manner (Bowlby; Granot & Mayseless; Sroufe, Fox, & Pancake, 1983). The

avoidant attachment style is characterized by a child-caregiver relationship that has one or more of the qualities that include lack of stability, emotional distance, reduced relational significance, and conventionality (Bowlby; Granot & Mayseless). Children with an avoidant attachment type have little emotional expression and often use denial or a neutral attitude when they respond to uncomfortable situations (Bowlby; Granot & Mayseless). The relationship between children with an ambivalent attachment style and their caregiver is strained (Bowlby; Granot & Mayseless). The caregiver is not available to the child, and the child often feels rejected by and is overly dependent on the caregiver. The caregiver and child frequently renegotiate their relationship (Bowlby; Granot & Mayseless). Children with ambivalent attachment types generally respond inappropriately to some situations, such as engaging in conflict at school (Bowlby; Granot & Mayseless). Ambivalently attached children may also express exaggerated and/or inconsistent emotions (Bowlby; Granot & Mayseless). Lastly, children with a disorganized attachment style have unconventional roles with their caregivers (Bowlby; Granot & Mayseless). The caregiver can be characterized as abusive, or the child may assume a dominant role in the child-caregiver relationship (Bowlby; Granot & Mayseless). Children express a disorganized attachment style through incoherent emotions and behaviors (Bowlby; Granot & Mayseless). Their emotional regulation strategies are generally comprised of aspects of secure, avoidant, and ambivalent attachment styles. Due to the introjection of fear in the child-caregiver relationships, survivors of incest and maltreatment often develop disorganized attachment styles

(Goldberg, Muir, & Kerr, 1995). Memory avoidance and psychopathology (e.g., borderline and avoidant personality disorders) are related to a lack of secure attachment among survivors of abuse (Alexander, 1993).

People are motivated to seek and receive attention from other people (e.g., Bowlby, 1980; Thompson, 1997), and children's ability to develop healthy, prosocial relationships with others is related to their attachment style (Bowlby; Granot & Mayseless, 2001; Sroufe et al. 1990). Children with secure attachment styles demonstrate social, emotional, and cognitive competence (Ainsworth, 1989; Ainsworth et al., 1978; Granot & Mayseless; Belsky & Cassidy, 1994), are less likely to have behavioral problems, and are better able to adapt to new situations (Thompson). Children with avoidant and disorganized attachment styles have higher levels of aggression and less social competence than other attachment style groups (Fagot & Kavanagh, 1990; Lyons-Ruth, Alpern, & Repacholi, 1993). It is concerning when children develop an ambivalent attachment type. Due to demonstrating inconsistent and/or inappropriate emotions, ambivalent children are unable to engage their peers (Granot & Mayseless; Cassidy & Berlin, 1994). Children's attachment style is related to their ability to engage and cooperate with their peers (Granot & Mayseless). The quality of peer relationships is related to positive outcomes, such as higher self-esteem, in adolescent and adult social development (Thompson).

During adolescence, secure attachment provides young people a sense of stability as they explore the world (Mercer, 2006). Mercer stated that many of the attachment needs of adolescents parallel the needs of toddlers. Like toddlers,

adolescents need supportive parents to assist with emotional, social, and cognitive growth even though adolescents may be resistant to help (Mercer). During the adolescent years, young people begin separating from their parents to achieve a greater sense of autonomy (Erikson, 1959; Mercer). A parental style based on fear and power is no longer effective as adolescents begin to gain power themselves (Mercer). If parents fail to compromise, negotiate, or address tasks/issues collaboratively with their adolescent, the adolescent may leave the home (Mercer). Chang, Schwartz, Dodge, and McBride-Change (2003) found that harsh parenting was positively related to aggression and negatively associated with child emotional regulation. Lack of parental involvement, weak parent-child attachment, and poor parental monitoring place children and adolescents at risk for engaging in delinquent behaviors, experiencing low self-esteem, and being aggressive (e.g., Barber, 1992; Barnow, Lucht, & Freyberger, 2005). Adolescents who experienced insecure attachment to caregivers may have developed negative models of self and/or others, may have difficulties trusting others, and may rely on others for a sense on worthiness (Blain, Thompson, &Whiffen, 1993).

Proactive parenting is most effective in assisting adolescents with their transition from childhood to adulthood (Kosterman et al., 2004). Adolescents with a secure attachment and proactive parenting will be better able to respond to the developmental challenges of puberty, social rejection, and changes in school obligations. Examples of proactive parenting include positive family management (e.g., clear expectations, consistent monitoring, and appropriate discipline), parental involvement (e.g., parent-child communication, satisfactory

parent-adolescent relationship), and appropriate awards from parents (Kosterman et al.). Kosterman, Haggerty, Spoth, and Redmond found that prosocial beliefs were positively related to parental involvement and parent-adolescent bonding and were negatively associated with antisocial behaviors among adolescent aged children.

Formoso, Gonzales, and Aiken (2000) found that children and adolescents' attachment to both father and mother moderated the relationship between family conflict and child/adolescent conduct problems. Parental monitoring by the mother and father moderated the familiar conflict/child outcome for both female and male children and adolescents. For females, parental monitoring and strong parent-child attachment were a protective factor for conduct problems. However, close monitoring and attachment was positively related to conduct problems among male children and adolescents. A strong, secure parent-child attachment was associated with positive outcomes in adolescent development. Adolescents with strong parental attachments were more likely than those with weak attachments to have higher self-esteem (Carr Jordan, 2008; Flouri, 2004), less substance use (Bahr et al., 1998; Brook, Cohn, & Jaeger, 1998), less relational aggression (Carr Jordan), and fewer sexual behaviors (Hart & Robinson Kurpius, 2005; Jaccard, Dittus, & Gordon, 1996).

The relationship between the adolescent and caregiver is important because it affects youths' interactions with others. Lynch and Cicchetti (1991) found that children and young adolescents' relationship style with their mothers were similar to the patterns reported in other peer and non-parental adult

relationships. When these researchers compared non-maltreated children and adolescents to those who were maltreated, they found that the maltreated children and adolescents had "confused" relational patterns with their mothers and others. Confused relational patterns can be problematic when engaging in adult relationships, such as choosing a life partner. For example, adults with insecure attachments are likely to choose mates with similar attachment styles, thus the family system is at high risk for perpetuating dysfunctional parenting and abuse (Goldberg et al., 1995). Research has found that attachment is significantly related to positive intra-and-interpersonal outcomes. Developmental models have been developed to provide insight to how attachment and childhood sexual abuse is linked to intra-and-interpersonal growth.

Developmental Models: Attachment and Childhood Sexual Abuse

Researchers have proposed models to understand better the impact of childhood sexual abuse on physical and psychological development (Alexander, 1992; Cole & Putnam, 1992; Freeman & Morris, 2001; Putnam, 1990; Spaccarelli, 1994). Developmental models purport that sexual abuse disrupts the natural growth of social and self-functioning. Interference with important developmental milestones results in severe short-and-long term symptomatology.

Alexander (1992) utilized attachment theory's (Bowlby, 1980; Crittenden & Ainsworth, 1989) framework to understand the long-term effects of childhood sexual abuse. Attachment theory states that child and caregiver interactions within the first year of life are crucial in a child's development of internal cognitive models and expectations regarding social relationships. The

information gained from child-caregiver interactions guides a child's social interactions (Bowlby, 1973). Alexander linked attachment theory and sexual abuse by considering how sexual abuse can occur within the family system and how survivors experience long-terms effects of sexual abuse. According to Alexander, sexual abuse is more likely to occur if either the abusive or nonabusive caregiver has a history of insecure attachments. Caregivers' who have developed an insecure attachment from childhood rejection, inappropriate roles or parentification, and unresolved trauma are less likely to meet the needs of themselves or others or to seek resources to help stop the sexual abuse.

Alexander (1992) also asserted that the long-term effects of childhood sexual abuse are related to the subtypes of an insecure attachment style (i.e. resistant, avoidant, and disorganized). Resistant attachment is related to interpersonal relationship problems, revictimization, anxiety, hypervigilance, and borderline personality disorder. PTSD symptoms and dissociation, as well as borderline and multiple personality disorders, may be related to disorganized attachment. Last, avoidant attachment may put childhood sexual abuse survivors at risk for denial or avoidance of the abuse and for reduced ability to engage in emotional expression or intimate interactions.

Cole and Putnam (1992) also applied attachment theory to explain the effects of childhood sexual abuse, although their model focused on the impact of incest on development. Child sexual abuse is egregiously problematic, because it disrupts the mastery of critical developmental milestones in childhood. For example, a child may develop ineffective or harmful coping strategies as a result

of experiencing sexual abuse (e.g., self-mutilation, suicide attempts). Similar to other developmental tasks, coping skill development depends on the child's age when the sexual abuse occurred as well as the duration of abuse. Preschool-aged children who are sexually abused may utilize the maladaptive coping responses of dissociation or denial, while school-aged survivors may feel guilt or shame as a result of their inability to engage in introspective coping strategies.

Spaccarelli (1994) used the transactional theory of development to explain the effects of childhood sexual abuse (Sameroff & Fiese, 1990). The transactional theory of development states that development occurs through a series of person-environment interactions. The nature of these interactions determines whether a person develops in a healthy or maladaptive manner. This theory purports that the environment is constantly changing and impacts the development of a person's intrapersonal resources. Internal resources, such as self-beliefs, affect how an individual organizes and responds to his or her environment. Instead of assessing specific episodes of sexual abuse, Spaccarelli examined how childhood sexual abuse affects a survivor's entire environment. Children with a history of sexual abuse experience a variety of stressors (e.g., changes in family relationships, coping, reactions to disclosure) that are directly related to aversive developmental outcomes. Spaccarelli stated that increased symptomatology results from the mediated relationship between the consequences of childhood sexual abuse and the development of maladaptive coping resources and cognitive appraisals.

Putnam (1990) combined developmental, dynamic, and biological theories to explain how incest interferes with the development of adaptive self-representations. The development of self-representations can be disrupted and thus results in subsequent intra-and-interpersonal problems, because sexual abuse creates an altered state of consciousness (e.g., dissociation). Survivors who lose memories of their childhood due to sexual abuse may develop a fragmented sense of self. Dissociation and the fragmentation of self may lead to psychopathology, such as multiple personality disorder or borderline personality disorder. Also, survivors who perceive a loss of self-control could experience altered states of consciousness triggered by the environment, such as dissociation or flashbacks. Sexual abuse can cause disturbances in other areas of development, such as sexual identity (e.g., revictimization later in life, unhealthy relationships), body image (e.g., conversion behaviors, self-mutilation, eating disorders), and low self-esteem.

Developmental models assist researchers and therapists in understanding how attachment and a history of childhood sexual abuse affects intra-and-interpersonal growth (e.g., Cole & Putnam, 1992). Prominent developmental models postulate that histories of childhood sexual abuse undermines survivors' secure attachment styles. Insecure attachment styles are correlated with negative psychological and social outcomes. Other models, such as transactional and biological theories, include the effects of the environment and consciousness on development (e.g., Putnam, 1990; Spaccarelli, 1994).

The Relationship of Attachment and Childhood Sexual Abuse

Research has found that a history of childhood sexual abuse is related to both adult attachment style and psychological outcomes. In a methodologically sound study, Roche, Runtz, and Hunter (1999) examined the association between childhood sexual abuse, adult attachment, and psychological adjustment among 307 university students. For women, a history of childhood sexual abuse was negatively related to psychological adjustment; this relationship was mediated by adult attachment. Women who were sexually abused by family members reported problems with depression, PTSD, identity problems, and anxiety. Compared to non-abused women, survivors reported more fearful, insecure attachment styles. In addition to experiencing a greater number of psychological concerns, women who were abused by family members were more insecure than survivors of extrafamilial abuse. Compared to survivors of intrafamiliar abuse, women who were sexually abused by a perpetrator outside of the family had an attachment style that was more dismissive. Roche and colleagues found that survivors of sexual abuse viewed themselves as unworthy of love and support in relationships. Sexual abuse violates a child's sense of safety and trust, thus disrupting the developing sense of self. If the self does not integrate properly or develops negatively, people will have difficulties maintaining satisfying relationships with the self-and-others long after the sexual abuse has occurred (Cole & Putnam, 1992; Muller & Lemieux, 2000). In fact, a history of childhood sexual abuse is reported in many studies as a risk factor for issues with intimate partnerships (i.e. higher separation and divorce rates among survivors) and parenting (e.g., lack of

confidence, parent-child role reversal) (e.g., DiLillo, 2001; Liang, Williams, & Siegel, 2006; Mullen et al., 1994; Rumstein-McKean & Hunsley, 2001).

Survivors may be hesitant to disclose their sexual abuse to family members, because they are afraid of not being believed, causing family problems, or feeling shame (Crisma, Bascelli, Paci, & Romito, 2004). After assessing survivors' needs following sexual abuse, Crisma et al. reported that survivors' top two needs were being able to talk with a nonjudgmental person who was willing to listen sympathetically and to receive counseling and information from those experienced with sexual abuse. In fact, research has shown that supportive relationships can be a protective factor against the negative psychological outcomes (e.g., anxiety, depression) associated with childhood sexual abuse (Adams & Bukowksi, 2007; Whiffen, Judd, & Aube, 1999). Notably, parental care and support are positive predictors of recovery following sexual abuse (Lynskey & Fergusson, 1997; Spaccarelli & Kim, 1995). Aspelmeier, Elliott, and Smith (2007) reported that higher levels of secure attachment in close-parental, adult, and peer relationships were correlated with fewer sexual abuse related symptoms among college females. In another study, Murthi and Espelage (2005) found that survivors who perceived their family as supportive reported fewer losses (i.e. loss of optimism, self, and childhood) than survivors who did not feel familial support. Whiffen et al., concluded that intimate relationships moderated the association between depression and childhood sexual abuse. Survivors who

perceived their intimate relationships to be of high quality were less vulnerable to depression as compared to survivors who viewed their relationships as low quality.

Summary of Child/Adolescent Development, Attachment, and Childhood Sexual Abuse

Strong parental attachment is crucial for developing an integrated sense of self and healthy interpersonal relationships. Young people who have strong parental attachments demonstrate better psychological and social functioning than those who have insecure attachment styles. Poor parental attachment and a history of child sexual abuse are related to negative outcomes, such as poor peer relationships, ineffective coping, and low levels of self-beliefs (i.e. self-esteem and mattering).

General Overview of Social Development

People begin to develop social skills as toddlers and continue to do so through late adolescence and early adulthood (Ladd & Price, 1987; Thompson, 1999). Researchers often use caregiver, teacher, or peer reports to assess children's social development and behaviors. In childhood, people begin to demonstrate prosocial or antisocial skills. It is important for researchers to understand the factors related to the development of prosocial behaviors, because these skills are necessary for maintaining functional relationships in adulthood (e.g., Cairns & Cairns, 1994). One indicator of a child's development of prosocial skills is his or her ability to cooperate with other children (Ladd & Burgess, 1999). Children must learn how to share, identify and adjust group goals, and

work together in social groups (Ladd & Burgess; Bukowski, Newcomb, & Hartup, 1996; Piaget, 1965). Children also need to have positive conflict resolution skills. During conflict, children with adaptive behaviors will demonstrate emotional control, will be able to share their thoughts and feelings in an appropriate manner, and will develop positive solutions for the problem (Piaget).

There are two main indicators of children's social maladjustment, aggression and antisocial behavior (Ladd, 2006). Aggression and antisocial behaviors are concerning because children's lack of social development is related to psychological maladjustment (Ladd & Burgess, 1999). Children with ineffective social skills often demonstrate confrontive and nonconfrontive aggressive behaviors (Ladd & Burgess). Children who use confrontive behaviors use direct acts and may yell, hit, and verbally or physically intimidate other children (Ladd & Burgess). Confrontive children demonstrate poor emotional control and can become aggressive when they feel threatened or want to achieve a social goal (i.e. make gains in peer status) (Erdley & Asher, 1996/1998; Lochman, Wayland, & White, 1993). Children with nonconfrontive aggressive behaviors use indirect acts, such as manipulation and exclusion strategies, in peer relationships (Cairns & Cairns, 1994; Crick & Grotpeter, 1995; Ladd & Burgess) and may start rumors, share secrets inappropriately, or exclude other peers from their group (Ladd & Burgess).

The second main maladaptive social skill is antisocial behaviors (Ladd & Burgess, 1999). Children who demonstrate antisocial behaviors often work alone, do not interact much with teachers or other peers, and will not engage in expected levels of communication with others (Ladd & Burgess; Rubin & Asendorpf, 1993). These children will withdraw from groups and refrain from developing peer relationships (Ladd & Burgess). Peers often reject children who are antisocial or aggressive (Laursen et al., 2007; Ladd). Children with antisocial tendencies have a low social status in school settings (Laursen et al.). If not resolved, behavioral problems can continue to be related to difficulties engaging in peer relationships in adolescence.

Peer interactions are crucial for children's cognitive, affective, behavioral, and social development (Hepler, 1997). Hartup (1983) stated that family and peer relations are important for socialization in most cultures. In Western and hunter-gather societies, children learn from each other (Hartup). While the circumstances related to child interactions differ across cultures, children have much opportunity for interaction with other children (Hartup). Children begin engaging their peers at a young age, and the frequency of these interactions increases with time (Brownell, 1990; Hartup). Research shows that 10% of two-year-old children's interpersonal interactions are with peers, and this percentage of peer engagement increases to 50% for 11-year-olds (Brownell). Research has also found that children demonstrate a strong same-sex friendship preference (e.g., Graham & Cohen, 1997). As youth enter their adolescent and young adult years, they spend a majority of their time with peers (Hartup).

Children must learn a variety of social, cognitive, and affective skills to interact effectively with their peers (Hepler, 1997). In order to have productive play, young children must learn how to manage conflict and to maintain emotional control (Hepler). From early to middle childhood, youth experience a shift in their self-knowledge. During this time, children begin to have more realistic self-appraisals, domain specific evaluations occur, general self-worth develops, and self-acceptance becomes increasingly related to interpersonal appraisals (Harter, 1990; Marsh, Craven, & Debus, 1998). As children age to between eight and 12 years, they must be able to understand and conform to group norms, and they must be able to feel comfortable with and be able to participate in peer groups (Hepler). In adolescence through early adulthood, the ability to understand one's self in relation to others, to reason, and to develop solutions for problems are important social skills (Gottman & Mettetal, 1986; Hepler). Skills required for positive peer interactions include effective communication skills, the ability to engage in activities, develop friendships, and to problem-solve (Hartup, 1983; Hepler). Children acquire social competencies through play activities and peer interactions with other children (Hepler). Throughout their lifespan, peer activities allow people to practice necessary social skills, to obtain immediate feedback from others, and to assess the effectiveness of and change their social behaviors (Hepler).

The Connection of Peer Relationships with Social Development

Developing adaptive social skills is necessary for maintaining peer relationships. Children and adolescents who are able to develop friendships have stronger self-esteem, better psychological health, and more social-self acceptance (Berndt & Burgy, 1996; Qualter & Munn, 2002; Rubin & Stewart, 1996; Rubin et al., 1995). Young people with high social-self acceptance feel liked by their peers and then like themselves more in turn (Rubin et al.). A child or adolescent with friends often views him-or-herself more positively because the peer group reinforces his or her positive attributes and downplays his or her shortcomings (Keefe & Berndt, 1996; Savin-Williams & Berndt, 1990). Children with strong friend networks (i.e. high social status) are better psychologically adjusted and are better able to adapt to academic and social situations (Hansen, Gaicoletti, & Nangle, 1995; Ladd & Burgess, 2001; Ladd, Kochenderfer, & Coleman, 1996; Parker & Asher, 1993; Savin-Williams & Berndt, 1990).

Youth who do not develop strong peer relationships and are rejected by peers often experience early and later life adjustment problems (Cairns & Cairns, 1994). Studies have found that peer rejection is associated with several negative outcomes, such as decreases in classroom participation (Ladd, Herald-Brown, & Reiser, 2008), externalizing and internalizing problems (Ladd, 2006; Ladd, Herald, & Andrews, 2006; Ladd & Troop-Gordon, 2003), social isolation (Laursen et al., 2007; Zettergren, 2005), and aggression toward peers (Guerra, Asher, & DeRosier, 2004). Also, Culotta and Goldsten (2008) found that compared to youth who were not jealous, adolescents who were jealous of their

peers demonstrated more relational aggression (i.e. harming others by manipulating social relationships) and proactive social behavior. Proactive social behavior has been associated with a feeling of being motivated by the expectation of a desired outcome that results from one's behavior (Boxer, Tisak, & Goldstein, 2004).

In adolescence, young people experience unique social development tasks. Adolescents begin to form deeper levels of friendship and engage in romantic relationships (Connolly, Furman, & Konarski, 2000). An increased need for peer networks emerges as young people become more autonomous and seek confidants with whom they can discuss their personal lives, peer relationships, and challenges (Claes, 1992; Pollack & Shuster, 2000). Hay and Ashman (2003) found that adolescents' same-and-opposite sex peer relationships influenced emotional stability more than did parental relationships. Hay and Ashman's results support attachment theory's tenant that adolescents begin to transfer their emotional attachment from parents to peers. Adolescents who feel support from their peers have less psychological or school-related problems, less loneliness, and are more confident that peers accept them (Bagwell, Newcomb, & Bukowski, 1998; Hay & Ashman; Newcomb, Bukowksi, & Pattee, 1993). Social isolation is a painful experience for adolescents and is correlated with low self-esteem and greater psychological maladjustment. Hall-Lande's research team (2007) reported that social isolation was positively related to symptoms of depression, suicide attempts, and low self-esteem. However, adolescents who perceived themselves as having strong family and peer networks were less likely than those

without social support to attempt suicide. DeWilde, Kiennhorst, Diekstra, and Wolters (1993) found that adolescents who felt supported by school staff, family, or peers utilized more effective coping strategies and felt positively about their future.

Peer relationships can also negatively impact adolescent development and lead to aversive outcomes (Abecassis et al., 2002; Hartup, 2001; Rubin, Bukowski, & Parker, 1998). Relationships with deviant peers are particularly problematic for adolescents. Researchers have consistently found that an association with deviant or socially isolated peers is related to the negative adolescent outcomes of delinquency (Vitaro, Brendgen, & Tremblay, 2000), aggression (Capaldi et al., 2001), police arrests (Patterson, Dishion, & Yoerger, 2000), and other types of antisocial behavior (Stoolmiller, 1994). These maladaptive links seem to be stronger among young people who have close relationships with highly antisocial peers (Huey et al., 2000; Morgan & Grube, 1991). Adolescents most likely will not have satisfying relationships with or learn appropriate social skills from antisocial (e.g., disruptive, aggressive, or at-risk behaviors) friends (Capaldi et al.; Miller, Loeber, & Hipwell, 2009; Patterson et al.; Thornberry, Freeman-Gallant, & Lovegrove, 2009). Thus peer relationships with friends who are antisocial can exacerbate the issues related to negative family relationships (Dishion et al., 1995; Dishion et al., 1991; Frauenglass et al., 1997).

To examine how peer rejection is related to aggressive or withdrawal behavior and psychological maladjustment, Ladd (2006) completed a longitudinal study that tracked children from ages five to 12. Identical measures were administered throughout the study. To assess children's aggressive behavior, peers and teachers rated participants' verbal and physical behaviors. Peers and teachers also rated participants' perception of peer group rejection. Teachers provided ratings of students' withdrawn and antisocial behaviors, as well as their tendency to externalize or internalize problems in the classroom. Children who externalized problems had difficulties controlling their emotions and behaviors. They generally were viewed as disruptive in class, hyperactive, distractible, having "delinquent" behaviors, or blaming other people (i.e. teachers or peers) for their social difficulties. Children who internalized problems tended to blame themselves for personal difficulties and demonstrated emotional and behavioral indications of anxiety and depression. The main findings of Ladd's study were that together aggressive behavior and peer rejection was a stronger additive predictor of externalizing problems in early versus later childhood. Peer rejection was a distinct predictor of children's internalization of problems in early childhood, which increased progressively over time. While Ladd did not focus on sex differences in this study, other research has revealed that girls tend to internalize problems more than do boys and that boys have more externalizing problems than do girls (Nolen-Hoeksema, Girgus, & Seligman, 1994; Rutter, 1986; Troop-Gordon & Ladd, 2005).

Using a longitudinal study design, Ladd, Herald-Brown, and Reiser (2008) assessed the relationship between peer group rejection and children's participation in the classroom. Ladd et al. followed 398 children from ages five to 12. These children were examined during and after peer rejection. Peer rejection and classroom participation was documented through peer, teacher, and classroom observer ratings of children's behaviors. There was high reliability among rating codes in this study. Children participated in the classroom less during periods of peer rejection; however, children who were not rejected demonstrated positive growth in class participation over time. Ladd et al. also found that when peer rejection ceased, children became more cooperative and active in class.

Lansford (2003) and colleagues followed 362 families annually from kindergarten through the seventh grade to assess if peer relationships moderate the association between negative parenting and adolescent externalizing behavior. Data were collected through self-report measures and interviews with mothers, teachers, and the adolescents. The relationship between negative parenting (e.g., parental monitoring and harsh discipline) and externalizing behaviors in the seventh grade was attenuated by adaptive peer relationships and exacerbated by associations with antisocial peers. Second, the relationship between unilateral parental decision-making (i.e. parents make decisions for the adolescent) and externalizing behavior was amplified among adolescents who had low quality friendships and associations with antisocial peers. Peer group affiliation and friendship quality were protective factors for adolescents with parents who

engaged in unilateral decision-making as well as low parental awareness of their child and low parental supervision.

Summary of Child and Adolescent Social Development

The social development literature reports that maladaptive peer relationships and peer rejection can have long-lasting and detrimental effects on the social development of youth. People who work with young people, professionals and caregivers alike, should be aware of the factors that are negatively related to social skill development. Engaging with peers is a crucial aspect of child development and must be fostered in school and home settings.

Coping Responses to Childhood Sexual Abuse

Coping is defined as allocating behavioral and cognitive efforts to respond to specific internal and/or external demands that are perceived as straining or exceeding an individual's resources (Lazarus & Folkman, 1984). Lazarus and Folkman purported that the level of threat put forth by the stressor and one's appraisal of the control one has in a situation affect an individual's selection of coping strategies. When responding to stress, people will engage in primary and secondary appraisals of the situation (Lazarus, 1991). During primary appraisal, individuals decide how they will be both positively and negatively impacted by environmental influences. Next, secondary appraisal occurs when people ask themselves if they can do anything in response to the stressor. If the answer to this question is yes, then other questions arise: What is the demand required, and how will this situation influence well-being? There are three appraisal options: 1) Harm/loss occurs when a person has previously experienced an event that cannot

be changed, 2) a threat appraisal is considered if a person is concerned he or she might experience a loss or will become hurt, and 3) challenge calls for the activation of coping resources (Lazarus).

People may utilize ineffective coping strategies when faced with multiple stressors because their adaptive coping strategies may become depleted (Baumeister, Faber, & Wallace, 1999; Hobfoll et al., 1996). Researchers argue that coping strategies may become depleted or unstable due to the effects of attachment (Crittenden, 1992). The type of attachment a person develops impacts his or her expectations of future interpersonal interactions. The working models that people develop impact their ability to engage in effective coping. Children may develop negative internal working models and coping strategies through their interactions with neglectful or abusive parents. Certain coping strategies, such as emotion focused coping, may be beneficial in helping the child cope in the short term. However, short-term, ineffective coping strategies may have aversive effects on one's internal working model. The coping strategies, generally detached and avoidant coping, developed from an insecure attachment style become maladaptive and cause problems with later interpersonal relationships (Shapiro & Levendosky, 1999).

Lazarus and Folkman (1984) stated that coping strategies can be globally categorized as emotion-focused coping and problem-focused active coping. Emotion-focused coping is used to regulate emotions in response to a stressor and include the strategies of distancing, avoidance, self-blame, and controlling feelings. Problem-focused active coping utilizes behaviors (i.e. seeking social

support, confrontation, and developing a proactive response plan) to manage stressors. Lazarus and Folkman postulated that emotion-focused versus problem-focused active coping would be more likely to be used if stressors and/or events were perceived by the individual to be out of his or her control. Thus, it can be expected that sexual abuse survivors are more likely to utilize ineffective coping strategies (i.e. emotion focused coping or disengagement strategies) (e.g., Leitenberg, Gibson, & Novy, 2004).

Taylor (1983) reported that coping with threatening events requires three cognitive tasks: 1) Searching for meaning, which "is the need to understand why the crisis occurred and what its impact has been" (p. 1162); 2) reaffirming a sense of mastery or "gaining a feeling of control over the threatening event so as to manage it or keep it from occurring again" (p. 1163); and 3) self-enhancement or "finding ways to feel good about oneself again" (p. 1161). Sexual abuse survivors may have difficulties completing these coping tasks. Self-blame, feelings of stigma, avoidance, and low self-esteem are related to poor coping skills and negative psychological outcomes among sexual abuse survivors (Gibson & Leitenberg, 2001; Leitenberg, Greenwald, & Cado, 1992; Spaccarelli, 1994). Survivors who use ineffective coping skills (i.e. emotion focused, avoidance focused, or disengagement methods) report experiencing problems with depression, anxiety, distress, low self-esteem, and personality disorders (Endler & Parker, 1990; Moos, 1990; Shea, Zlotnick, & Weisberg, 1999). Johnson, Sheahan, and Chard (2003) found that female survivors with PTSD compared to those without PTSD had greater rates of dependent and avoidant

personality disorders, which suggests that a history of sexual abuse is correlated with negative psychological outcomes.

Brand and Alexander's (2003) study examined the relationship between coping and adult functioning in 101 adult female survivors of incest. After controlling for abuse characteristics (e.g., age of onset), the researchers found that avoidance coping was related to greater adult dysfunction, while distancing (e.g., moving away from abusive circumstances) was correlated with less adult dysfunction (e.g., depression, distress). Survivors who engaged in avoidance coping strategies following sexual abuse reported higher levels of depression and distress. Brand and Alexander's findings were similar to those of Johnson and Kenkel (1991) who found that adolescent incest survivors' higher levels of distress were associated with the use of avoidance coping strategies. Avoiding the memory of sexual abuse may assist women with coping in the short term. However, due to the interference of mood and the development of ineffective coping strategies, avoidance coping strategies are related to poorer adult functioning. Similar to other study results (e.g., Herman, 1992), participants in Brand and Alexander's study rarely engaged in problem-focused coping strategies. Survivors of childhood sexual abuse thought they were powerless, thus the most viable coping strategy available to them was emotional management. Similar to Brand and Alexander, Filipas and Ullman (2006) examined the relationship between child sexual abuse and outcome variables that included coping.

Filipas and Ullman (2006) surveyed 577 female college students to assess the relationship between child sexual abuse, self-blame, coping, PTSD, and adult sexual revictimization. Roughly 16% of participants reported experiencing child sexual abuse, 10% were sexually assaulted as adults, 12% were sexually abused as children and adults, and 61% did not report experiencing sexual abuse. More than half and approximately one fifth of child sexual abuse survivors experienced sexual fondling and penetration. Almost half of the perpetrators were reported to be non-family members, and two thirds of the participants experienced abuse that lasted from weeks to years. More than half of the survivors blamed themselves at the time when the sexual abuse occurred, and 41.5% of the survivors still blamed themselves for the sexual abuse. The most common coping strategy following the sexual abuse was to avoid or try to forget the experience. In addition, almost half of the female survivors withdrew from people. Compared to survivors who only experienced childhood sexual abuse, survivors of both child sexual abuse and adult sexual abuse coped by using drugs or alcohol, withdrawing from others, and engaging in risky sexual behaviors. Consistent with other study results (e.g., Moeller, Bachmann, & Moeller, 1993; Ullman & Brecklin, 2002), Filipas and Ullman found that women who were revictimized also had higher levels of PTSD symptoms and were more likely to seek counseling services than survivors of only child sexual abuse. Child sexual abuse survivors who engaged in self-blame during the abuse were one and a half time as likely to use ineffective coping methods, such as withdrawal from people, drug and alcohol use, and sexual and/or aggressive behavior, in adulthood. The use of ineffective coping strategies

was correlated with revictimization. Compared to participants who did not utilize maladaptive strategies, those who engaged in ineffective coping were almost twice as likely to be revictimized.

Gender Differences and Coping among Childhood Sexual Abuse Survivors

There is a dearth of studies that have assessed the gender differences among the coping strategies used by sexual abuse survivors. The literature suggests that women are more likely than men to experience symptoms of PTSD following sexual abuse. Feiring, Taska, and Lewis (1999) found that girls, as compared to boys, experienced greater levels of hyperarousal, intrusive thoughts, and feelings of vulnerability and being unsafe. The need to protect the self from shame typically leads to rage in men and to depression in women (Cutler & Nolen-Hoeksema, 1991; Lewis, 1971, 1992; Tangney, Burggraf, & Wagner, 1995). Furthermore, female survivors experience greater shame than male survivors if they perceive themselves as having broken a rule or not meeting self-or-other imposed expectations (Lewis, 1992; Tangney, 1991). Shame can also arise from women's likelihood of developing self-blaming attributions about the sexual abuse (Lewis, 1992; Tangney).

In the United States, child sexual abuse occurs in a "gendered" society where men have more power than women (Ullman & Filipas, 2005). Rosario, Shinn, Morch, and Huckabee (1988) theorized that the socialization differences among men and women are related to the gender differences found for coping styles. Their theory purports that men are more likely to engage in problem-

focused coping, because they are socialized to be more self-reliant and active. Men would utilize problem-focused coping in an attempt to reduce their stress levels by changing the situation. Men are expected to manage stress instrumentally, while women are socialized to express emotion and to solicit support from others. Women, therefore, would be more likely than men to engage in emotion-focused coping due to attempting to manage their emotions versus trying to change the sexual abuse situation.

Sexual abuse is more frequent and severe among women than among men, although researchers believe that the sexual abuse of men is underreported (Boney-McCoy & Finkelhor, 1995; Salter, 1992). Even though there are several gender differences in women and men's responses to child sexual abuse, both men and women are more symptomatic if their father figure sexually abused them. Banyard, Williams, and Siegel (2004) compared the hospital records of adult male and female survivors of childhood sexual abuse and found that relative to the men, women had more symptoms that were explained by a close survivor-perpetrator relationship, the use of physical force, being of an older age when the abuse occurred, and other traumas during their lifetime. Men's symptoms were related to the number of sexual abuse incidents, injury caused by a caretaker, and other traumas that occurred in adulthood (Banyard et al.).

Studies assessing childhood sexual abuse coping strategies have found that men engage in externalizing behaviors, while women generally utilize internalizing behaviors (Feiring et al., 1999; Gomez-Schwartz, Horowitz, & Cardarelli, 1990; Ullman & Filipas, 2005). For example, studies report that male

survivors utilize externalizing coping behaviors as demonstrated by their tendency to act aggressively toward others (e.g., Gomez-Schwartz et al.). Other studies have found that compared to women without a history of sexual abuse, survivors often use the internalizing coping behaviors of social withdrawal and/or use avoidance coping (e.g., Gibson & Leitenberg, 2001; Ullman & Filipas). When comparing male and female survivors of childhood or adulthood sexual/physical abuse, men report more substance use disorders (i.e. externalizing behavior) than do the women (Saladin et al., 2003).

Summary of Coping Strategies Associated with Childhood Sexual Abuse

Ineffective coping strategies can arise from poor relationships with parents and peers as well as from a history of child sexual abuse. Youth who are not securely attached to others and who do not trust or rely on others may develop ineffective internalizing and externalizing coping strategies. Young people, especially women, may also engage in emotion focused coping in an effort to manage their negative emotions. In addition to understanding how attachment and child sexual abuse impacts one's ability to learn and implement effective coping skills, researchers and therapists must also understand how poor attachment and child sexual abuse negatively impacts one's self-esteem and sense of mattering to others.

Understanding Self-Beliefs

The Necessity of High Self-Esteem

As young people transition from childhood to adolescence, they begin to experience a greater sense of autonomy. Adolescents are exploring their environment, experimenting with different social roles, and fostering more meaningful peer relationships. During this time, adolescents begin to transfer their attachment needs from their parents to their friends (Allen & Ladd, 1999; Fraley & Davis, 1997). Although adolescents are adjusting their attachment relationships and become less dependent on parents, this does not mean that the parent-child relationship is unimportant or less predictive of psychological outcomes. Researchers have found that a secure attachment in childhood and adolescence fosters adaptive identity development (Allen & Ladd). A secure parent-child attachment style provides a strong basis for young people to explore and engage in healthy intra-and-interpersonal developmental tasks. Secure attachment fosters the development of important self-beliefs, especially self-esteem.

Several studies have found that self-esteem impacts intra-and-interpersonal development outcomes (Pipher, 1994). Rosenberg (1965) defined self-esteem as one's general feelings of self-worth. Rosenberg (1979) purported that people with high self-esteem appreciate their merits, recognize personal faults, and expect to overcome challenges. Low self-esteem is associated with lack of self-respect as well as considering one's self as unworthy and inadequate. Coopersmith (1967) referred to self-esteem as "the evaluation which an individual

makes and customarily maintains with regard to himself; it is expressed as an attitude of approval or disapproval, and indicates the extent to which the individual believes himself to be capable, significant, successful, and worthy" (p. 4). Secure attachment with parents in childhood and adolescents is related to positive self-representations, such as high levels of self-efficacy and self-esteem (Arbona & Power, 2003). Negative interpersonal feedback can be detrimental for the children and adolescents, because self-esteem can be shaped by appraisals from others.

Self-esteem impacts people's emotions, behaviors, and psychological adjustment (Berk, 2003). Self-esteem levels predict psychological and relational outcomes during childhood and adolescence. High self-esteem levels are associated with adaptive coping skills (Baumeister et al., 1999), perceived happiness (Baumeister et al.), and life satisfaction (Huebner, 2001). Low levels of self-esteem have also been correlated with negative outcomes, such as poorer health (Murell, Meeks, & Walker, 1991). Increased externalizing behavior (Peterson, Leffert, & Graham, 1995), aggression (Donellan et al., 2005), substance use (Peterson et al.), teen pregnancy (Peterson et al.), violent or antisocial behavior (Donellan et al.), negative social interactions (Lakey, Tardiff, & Drew, 1994), and anxiety (Murell et al.) have been linked to low self-esteem.

Researchers have also consistently found self-esteem to be associated with depression (e.g., Dixon & Robinson Kurpius, 2008; Garber, Robinson, & Valentiner, 1997; Heyman, Dweck, & Cain, 1992) and to perceived stress (e.g., Dixon & Robinson Kurpius; Gloria & Robinson Kurpius, 2001; Kliewer &

Sandler, 1992; Wilburn & Smith, 2005). Poorer self-esteem is an at-risk factor for adolescent depression (Garber et al.). Among college students, Hermann and Betz (2006) reported a direct relationship between self-esteem and depressive symptoms. Self-esteem is also negatively related to life stress (Abramson, Metalsky, & Alloy, 1989.; Garber et al.; Kliewer & Sandler). People with higher levels of self-esteem perceive experiencing lower levels of stress. Positive self-esteem improves an individual's ability to cope with stress (Simonds, McMahon, & Armstrong, 1991) and is related to fewer suicidal thoughts (Wilburn & Smith).

Studies that have examined gender differences related to self-esteem have found mixed results. Some researchers have found that men and women typically report different levels of self-esteem with men reporting higher self-esteem (American Association of University Women, 1991; Lawrence, Ashford, & Dent, 2006). Using a longitudinal design, Block and Robins (1993) reported that women have a decrease and men have an increase in self-esteem during adolescence through early adulthood. However, Zuckerman (1980) reported that the self-esteem differences among college aged men and women tend to disappear. Similarly, Foels and Tomcho (2005) found that equivalent levels of collective self-esteem were reported among male and female college students.

Allen, Moore, Kupermine, and Bell (1998) studied the link between attachment and psychosocial functioning among 131 moderately at-risk adolescents age 14 to 18 years. The researchers assessed the adolescents' at-risk status by evaluating their current academic performance and the likelihood of their experiencing social or academic problems in the future. Self-reports, peer

reports, and maternal reports were used to examine adolescents' competency in peer relationships as well as the presence of internalizing and/or externalizing behaviors. Allen's research team also evaluated participants' perceptions of self-worth, maternal control, and the quality of the maternal-child relationship. Results showed a relationship between the psychosocial variables assessed (i.e. self-worth, control, and support) and attachment. The adolescents who were securely attached had lower levels of internalizing and deviant behavior. Securely attached adolescents also reported being more competent with their peers. Allen and colleagues found that insecurely attached adolescents reported greater levels of internalizing and deviant behaviors.

In another study utilizing the construct of attachment, Laible, Carlo, and Roesch (2004) worked with an ethnically diverse sample of male and female college students in order to assess the associations among parent and peer attachment, prosocial behaviors, and self-esteem. They found that attachment had a direct effect on self-esteem, and the link between attachment and self-esteem was significant for both sexes. While secure parental and peer attachments significantly impacted women's self-esteem, the relationship between attachment and self-esteem was stronger for the men than for the women.

Low levels of self-esteem have been consistently linked with ineffective coping strategies, such as engaging in externalizing behaviors and social withdrawal. Donnellan, Trzesniewski, Robins, Moffitt, and Caspi (2005) research team found a strong relationship between low self-esteem and externalizing problems (e.g., aggression, delinquency, antisocial behaviors) after controlling for

age groups, socioeconomic statuses, and ethnicities. Studying adolescents only, Parker and Benson (2004) examined the association between parent support and monitoring with higher self-esteem and less risk-taking behaviors. In accordance with Bowlby's (1969) attachment theory, Parker and Benson found that parental attachment and support were correlated with positive peer interactions. In addition, adolescents who viewed their parents as supportive reported higher levels of self-esteem as well as less school misconduct, delinquency, and drug and alcohol use.

In addition to being linked with parental and peer attachment and coping, self-esteem is also affected by childhood sexual abuse (Feiring et al., 1999; Hall-Lande et al., 2007; Mullen et al., 1996; Rosenthal, Feiring, & Taska, 2002). Based on the principles of social learning theory (Bandura, 1977/1978), it makes sense that childhood sexual abuse can negatively affect people's self-concepts. Social learning theory posits that children's understanding of their personal identities reflects how others react to them. A child may develop a maladaptive intrapersonal attitude if he or she perceives the attitudes and/or behaviors of others as negative. Negative events, such as childhood sexual abuse, can result in greater levels of self-focus and intrapersonal evaluation (Graham & Hoehn, 1995; Lewis, 1992). Feelings of shame and low self-esteem often arise from individuals' negative evaluations of their actions (Lewis) and internalizing a sense of "badness" from the abuse (Draucker, 1992; Lisak, 1994). A pessimistic attribution style, which includes having unstable, external, specific attributions for positive events and making stable, internal, global attributions for negative events,

is related to feelings of shame (Nolen-Hoeksema, Girgus, & Seligman, 1992; Tangney, Wagner, & Gramzow, 1992), to depressive symptomatology (Gold, 1986; Mannarino & Cohen, 1996; Nolen-Hoeksema et al., 1992; Spaccarelli & Fuchs, 1997; Tangney, Wagner, & Gramzow; Wolfe, Sas, & Wekerle, 1994), to anxiety (Spaccarelli & Fuchs; Wolfe, Sas, & Wekerle), to PTSD symptoms (Spaccarelli & Fuchs; Wolfe, Sas, & Wekerle), and to low self-esteem (Gold; Mannarino & Cohen).

Cole and Putnam (1992) identified themes that explain how a history of childhood sexual abuse is associated with long-term psychological problems. Their model demonstrates how exposure to stressful events, such as child sexual abuse, is negatively related to internal intra-and-interpersonal working or cognitive models. Cole and Putman believed that stressful events can result in people having difficulties managing and integrating aspects of the self as well as having struggles to develop trust in others. These self and social functioning issues can result in an incongruent sense of self (e.g., identity confusion), difficulties regulating emotions and impulse control, and feeling insecure with interpersonal relationships (e.g., suspiciousness) (Cole & Putman).

Examining the effects of shame and attribution style on adjustment following sexual abuse, Feiring, Taska, and Lewis (2002) assessed 147 children and adolescents at the time of sexual abuse and then again one year later. Children who continued to experience high levels of shame over a year's time were at risk for the poorest adjustment. In contrast, children who experienced a reduction in shame over time made improvements across all adjustment

indicators. Feiring et al. found that a pessimistic attribution style was related to poor adjustment (e.g., depression). Over one year's time, adolescent survivors demonstrated more depression and lower levels of self-esteem as compared to children. In an earlier study, Feiring, Taska, and Lewis (1999), also had found that adolescents reported greater depression, lower self-esteem, sexual anxiety, and negative reactions by others in comparison to the reports of children.

Self-esteem is enhanced through a secure attachment to parents and affects intra-and-interpersonal development (e.g., Pipher, 1994). Self-esteem is an important self-belief, because it is associated with psychological gains (e.g., Berk, 2003; Baumeister et al., 1999). While self-esteem is related to people's self-appraisals, counselors must examine people's perceptions of being valued by others (i.e. mattering).

The Effects of Perceived Mattering

A relatively new intrapersonal self-belief construct in the literature is mattering. Rosenberg and McCollough (1981) defined mattering as "the feeling that others depend upon us, are interested in us, are concerned with our fate, or experience us as an ego-extension" (p. 165). Social roles assist people in developing a sense of their own worth (Pearlin, 1983), which can serve as a protective factor against feeling alienated from others (Homans, 1951). While mattering has not been linked to childhood sexual abuse, the construct has been associated with other outcome variables such as interpersonal relationships, stress, depression, self-esteem, and job satisfaction (as cited in Dixon & Robinson Kurpius, 2008). Mattering is an important variable to link to child sexual abuse,

because it makes sense that a history of abuse would negatively correlate with survivors' self-beliefs about being cared for by others.

Marshall (2001) studied self-esteem and mattering among undergraduates and high school students and found that mattering was important for psychosocial well-being. He reported that compared to males, females believed that they mattered more to their friends and to their parents. Mattering has been positively related to self-esteem and negatively related to depressive symptomatology (Dixon & Robinson Kurpius, 2008; Rosenberg & McCullough, 1981). However, Taylor and Turner (2001) controlled personal and social factors and reported that mattering was a protective factor against depression only for the female participants. In another study assessing college students and clients, Hagerty and Williams (1999) asserted that a "sense of belonging" (mattering) was negatively correlated with depression. Examining stress and mattering among 388 school counselors, Dixon Rayle (2006a) found that mattering was a significant predictor of job-related stress. Counselors who thought that they mattered less experienced greater perceived job stress.

Dixon and Robinson Kurpius (2008) reported findings linking mattering and self-esteem to college stress and depression among 455 male and female undergraduate students. Similar to other researchers (Foels & Tomcho, 2005; Zuckerman, 1980), Dixon and Robinson Kurpius found no sex differences among self-esteem. Similar to the findings on self-esteem, there were no differences among men and women on mattering. Dixon and Robinson Kurpius suggested that both male and female undergraduates believed that they mattered to others.

They found that mattering and self-esteem were positively related. These results were not unexpected as mattering is one's perception of being valued by others and self-esteem is the belief that one is a person of worth.

Summary of the Importance of Self-Beliefs

Though limited in number, these studies (e.g., Dixon & Robinson Kurpius, 2008; Dixon Rayle, 2006a) suggest that mattering is negatively related to undesirable psychological outcomes, such as depression, job-stress, and college stress. Mattering is also positively related to self-esteem (Dixon & Robinson Kurpius). As one feels more valued by others, he or she feels more worthwhile as a person. Both mattering and self-esteem are important self-beliefs as they are predictors of psychological and social development. Thus, the lack of safety, violation of boundaries, confusion, and shame associated with child sexual abuse undermines a survivor's trust in others; therefore, it makes sense then that survivors of child sexual abuse might feel unvalued by others. A weak connection with parents and friends and a history of child sexual abuse most likely will result in survivors feeling that they do not matter to others.

The Current Project

The main organizing questions for this project were: Does a history of childhood sexual abuse and poor attachment to mother and father predict weak attachment to peers, ineffective coping skills, and a low sense of mattering? Are there sex differences among these outcome variables? Is perceived negative impact of the abuse related to perpetrator use of force, duration of the abuse, and severity of the abuse? Eligible participants for this study were between 18 and 24

years of age and had experienced sexual contact from a perpetrator before they were 18 years of age.

Hypotheses

It was hypothesized that:

H1: Participants with a childhood sexual abuse history will report poorer attachment to mother and father and less mattering to parents than will participants who reported no history of abuse.

H2: Participants with a childhood sexual abuse history will report less attachment and less mattering to peers than will participants who reported no history of abuse.

H3: Participants with a childhood sexual abuse history will report more emotion focused and less problem focused coping than will participants who reported no history of abuse.

H4: Female survivors of childhood sexual abuse will report more emotion focused and less problem focused coping than will male survivors of childhood sexual abuse.

H5: Female survivors of childhood sexual abuse will report a greater negative impact of the abuse than will male survivors.

H6: More force, greater perceived severity, and longer duration of the childhood sexual abuse experience will be related to a greater negative impact of the abuse.

H7: A history of childhood sexual abuse and attachment to mother and father will predict coping behaviors.

H8: A history of childhood sexual abuse and attachment to mother and father will predict attachment to friends.

H9: A history of childhood sexual abuse and attachment to mother and father will predict mattering to parents and to friends.

Definition of Terms

Sexual abuse. Sexual abuse was conceptually defined as any actual or implied sexual behavior forced upon an adolescent/young adult or the use of coercion for the perpetrator's sexual gratification (Browne & Finkelhor, 1987). Sexual behaviors included the child stimulating the perpetrator, the perpetrator's fondling of a child's breast, vagina, penis, or buttocks, and/or attempted or completed oral, vaginal, or anal intercourse. Sexual abuse, force, duration, severity, and negative impact were operationally defined by scores on the *Early Sexual Experiences Checklist* (Miller, Johnson, & Johnson, 1991).

Attachment. Attachment was defined as the participants perceiving that their mothers, fathers, and peers demonstrate that the participants are important and valued. Attachment was also defined as mothers, fathers, and peers approaching conflict with the participants in a positive manner by being reliable and proactive. Attachment was operationally defined as scores on the mother, father, and peer subscales of the *Inventory of Parent and Peer Attachment* (Armsden & Greenberg, 1987).

Problem-focused coping. This study focused on problem-focused coping, which was denoted by one's attempt to problem-solve or manage a problem's source (e.g., make a plan, change someone's mind). Problem-focused coping was

operationally defined as scores on the problem-focused coping and seeks social support subscales of the *Revised Ways of Coping Checklist* (Vitaliano, Russo, Car, Maiuro, & Becker, 1985).

Emotion-focused coping. Emotion-focusing coping was defined as using behavior or cognitions (e.g., forgetting, accepting sympathy) to manage emotional distress. Emotion-focused coping was defined as scores on the blamed self, wishful thinking, and avoidance subscales of the *Revised Ways of Coping Checklist* (Vitaliano et al., 1985).

Mattering. Mattering to parents and friends was defined as participants' perceptions that their parents and friends depend on, care about, and are interested in participants. Mattering was operationally defined as scores on the parent and friend subscales of the *Interpersonal and General Mattering Assessment* (Dixon Rayle, 2005).

Chapter 2

Method

Participants

Prior to recruiting participants for this study, approval was obtained from the Institutional Review Board (see Appendix A). Participant completion of the survey packet reflected informed consent to participate (see Appendix B for informed consent letter). Two individuals who were not yet 18 years old and nine individuals who did not identify age were deleted from the initial sample of 269 participants. The final study sample consisted of 258 at-risk male (*n* = 132) and female *(n* = 126) adolescents from a community agency who ranged in age from 18 to 25 with a mean age of 20.22 (*SD* = 1.91). When asked about racial/ethnic identity, 91 (35.8%) self-identified as Latino/a, 50 (19.7%) as White, 48 (18.9%) as Black, 28 (11%) as Native American, 11 (4.3%) as biracial, 9 (3.5%) as Asian American, 4 (1.6%) as Pacific Islander, and 13 (5.1 %) as other. Most were single (*n* = 213, 84.9%); although 35 (12.4%) reported being married (*n* = 7) or living in a committed relationship (*n* = 28). Three (1.2%) indicated that they were divorced or separated. Highest education attainment included 35 (14%) with some grade school, 19 (7.6%) with a 8^{th} grade education, 154 (61.6%) with a high school diploma or GED, and 42 (16.8%) with some college or technical training. The most prevalent religious affiliations were Catholic (*n* = 68, 28.2%) or Christian (*n* = 58, 24.1%), with 38 (15.8%) indicating no religious affiliation. Of those who reported sexual orientation, 180 (82.9%) reported being heterosexual, 32 (14.7%) bisexual, and 5 (2.3%) as gay or lesbian. The most prevalent family

structures were mother and father (*n* = 104, 40.8%), mother only (*n* = 77, 30.2%), mothers and stepfather (*n* = 27, 10.6%). Questions about parental educational attainment indicated that most mothers had a high school education or less (*n* = 176, 73.6%), as did fathers (*n* = 150, 73.9%). Approximately two thirds of the participants reported yearly parental household income levels less than $30,000. Table 1 in Appendix E presents demographic information for survivors and those with no history of childhood sexual abuse.

Participants were considered at-risk youth because many had a history of drug or alcohol use, had experienced child abuse, engaged in gang-related activities, or were homeless. When specifically asked about abuse history, 77 (41%) reported that they had been sexually abused as a child (17 years old or younger). Approximately 10 percent (*n* = 24) indicated that they were gang members. Participants were recruited to participate in this study by the mental health and residential staff and by course instructors. Participants completed a research packet during an individually scheduled meeting, during a group meeting, or during class sessions. Of those invited to participate, approximately 25 choose not to participate in the study.

Instrumentation

Participants completed a survey packet consisting of a demographic questionnaire (see Appendix C) and measures that assessed history of unwanted sexual experiences, attachment to mother, father, and peers, coping strategies, and mattering. A copy of the survey instruments are in Appendix D.

Early Sexual Experiences Checklist (ESEC). Miller, Johnson, and Johnson (1991) created this instrument to detect child sexual abuse. This measure is relatively noninvasive due to being a direct checklist that excludes the use of judgmental or pejorative terminology. Miller and colleagues designed the ESEC to avoid requiring participants to label themselves as being "sexually abused" and to make distinctions among abuse categories (e.g., oral sex versus intercourse). The ESEC asks participants to select unwanted sexual experiences as a child. Researchers can utilize diverse operationalizations of unwanted child sexual experiences because the ESEC inquires about 1) the participant's age during the abuse, 2) the age of the perpetrator, and 3) the use of coercion.

The ESEC (Miller et al., 1991) is comprised of three subscales. The first subscale includes 10-items that list unwanted sexual experiences. The tenth item asks participants to describe other unwanted sexual behaviors they have experienced. Participants also have the option to indicate none of the above behaviors occurred. Participants are asked to check all the unwanted sexual experiences that apply. The number of items selected is summed with total scores reflecting more incidents of unwanted sexual experiences, which reflects greater severity. Total scores for unwanted sexual experiences can range from one to 10 and were used as a measure of severity. If a participant indicated any unwanted sexual experience as a minor, for the purposes of this research, they were considered as having a childhood sexual abuse history.

After completing the first subscale, participants were asked to identify from the list of 10 unwanted sexual experiences the most "bothersome" experience. They then completed items about themselves and their perpetrator, such as 1) the participant's sex, 2) the participant's age at the time of the most bothersome unwanted sexual experience, 3) type of perpetrator (i.e. stranger, friend/acquaintance, or relative), and 4) the duration and frequency of the most bothersome unwanted sexual experience. Then participants rate the behavior they chose as the most bothersome on a scale from 1 (not at all) to 7 (extremely). The two items rated are: "How much did the experience bother you at the time?" and "How much does the experience bother you now?" To create a bothersome score, the two responses were summed creating a score that could range from two to 14. Higher scores reflected participants' experiences of unwanted sexual behaviors as more bothersome. This bothersome score was used a measure of the negative impact of the childhood sexual abuse. In addition, two items asked about the duration of abuse: 1) "How many times did this behavior occur?" which had response options of "just once," "twice," "3 or 4 times," and "5 times or more" and 2) "Over how long a period did this behavior occur?" which had response options of "just once," "a month or less," "several months," and "a year or more." The answers to these two individual questions were used as measures of duration.

The last subscale, which consists of 10 items, assessed participants' experiences of psychological pressure or physical force during unwanted childhood sexual experiences. Sample items include, "They tried to talk you into it" and "They pushed, hit, or physically restrained you." Participants checked any

item that was related to their one most bothersome unwanted sexual experience. The number of items checked was summed, with higher total scores, which could range from zero to nine, reflecting more psychological pressure or physical force during the one most bothersome unwanted sexual experience in childhood.

The ESEC has been reported to have strong reliability and validity. Miller and Johnson (1997) reported a Cohen's kappa (which conservatively corrects for chance agreements on different categories) of .92 for an average 1-month test-retest reliability. The ESEC captures sexual abuse experiences not detected in other measures. For example, Miller and Johnson found that 56% of a college sample who had reported experiencing unwanted sexual behaviors during childhood did not identify as being "sexually abused." Anderson, Miller, and Miller (1995) found that those who had unwanted sexual experiences during childhood as reported on the ESEC had greater depression and neuroticism, as well as lower self-esteem, compared to those who did not report child sexual abuse. Furthermore, compared to those who reported experiencing less severe unwanted sexual behaviors, participants who experienced severe forms of child sexual abuse were less secure, more avoidant, and more anxious in their relationships. Severely abused participants were also more impulsive and used more drugs and alcohol than those with less severe sexual experiences. For this study, Cronbach's alphas for the subscales examining severity of childhood sexual abuse experiences, the negative/bothersome impact of abuse, and force used by the perpetrator during the unwanted childhood sexual abuse experience were .91, .88, and .84, respectively.

Inventory of Parent and Peer Attachment (IPPA). This inventory includes three, 25-item measures that assess adolescents' attachment to father, to mother, and to peers (Armsden & Greenberg, 1987). Sample items regarding parental attachment include "I trust my father" (attachment to father subscale) and "I can count on my mother when I need to get something off my chest" (attachment to mother subscale). Sample items from the attachment to peers scale are "I can tell my friends about my problems and troubles" and "my friends help me to understand myself better." These self-descriptive items are responded to using a 5-point Likert-type format. Responses range from 1 ("Almost never or never true") to 5 ("Almost always or always true"). Each attachment instrument (mother, father, peers) is scored independently (Armsden & Greenberg, 1987). Total attachment scores for mother, father, and peers are each produced after several items are reversed scored and then the responses to the 25 items within each measure are summed. Possible scores range from 25 to 125, and higher scores are associated with greater attachment.

There were no norms available for the IPPA; however, two samples of undergraduate students at a northwestern university were used to develop this measure. A majority of these students were Euro-American and ranged from 16 to 20 years old. Sixty-three percent of these participants were female. Armsden and Greenberg collected internal consistency data on the original IPPA, which did not differentiate attachment to mother and to father. Armsden and Greenberg conducted a test-retest study with a three-week interval and found reliabilities of .93 for parental attachment and .86 for peer attachment. Testing the IPPA's

construct validity, Armsden and Greenberg predicted that adolescents with higher peer and parental attachments would score higher on assessments of well-being, as well as report fewer psychological symptoms when confronted with negative life changes. The researchers predicted that adolescents who varied on peer and parental attachment would also differ on measures of well-being (i.e. self-concept, self-esteem, life satisfaction). The data supported the author's predictions. Using previously validated instruments of self-concept and affect (e.g., the Tennessee Self-Concept Scale and Bachman's Affective State Index), the authors assessed construct and convergent validities. IPPA scores were negatively associated with depression and loneliness. Last, the IPPA also differentiated delinquent from non-delinquent adolescents.

Current research provides additional support for the original IPPA reliability data. Akkapulu (2005) found an internal consistency coefficient of .91 for peer attachment, and Maier, Bernier, Pekrun, Zimmerman, and Gorssmann (2004) reported internal consistencies of .89 and .85 for the attachment to mother and father scales, respectively. Hart's (2000) Cronbach's alphas were .97 for the Father Attachment scale, .93 for the Mother Attachment scale, and .93 for the Peer Attachment scale. Kirton (2000) reported internal consistencies of .95 for attachment to mother, father, and peers. Carr-Jordan (2008) reported Cronbach's alphas of .92 and .96 for attachment to mother and attachment to father, respectively. This study's Cronbach's alphas for attachment to mother, to father, and to friends were .94, .89, and .92, respectively.

Revised Ways of Coping Checklist. Participants' coping strategies were assessed using the 42-item *Revised Ways of Coping Checklist* (WOCC; Vitaliano et al., 1985). Participants were instructed to complete the measure with respect to how they deal with stressors in their life. This instrument has five subscales: 1) Problem-focused coping; 2) seeking social support; 3) avoidance; 4) wishful thinking; and 5) blame others. Vitaliano et al. (1985) revised Folkman and Lazarus' (1980) *Ways of Coping Checklist* (WCCL). Folkman and Lazarus created a 68-item instrument that assessed behavioral and cognitive coping strategies that a person utilizes during a stressful event. Folkman and Lazarus developed their measure's coping strategies from Lazarus (1966) and Lazarus and Launier's (1978) research on coping. Folkman and Lazarus asked participants to think about a particular stressful event while they answered survey items either yes or no. The original measure, *Ways of Coping Checklist*, classified items into two 21-item subscales, either problem-focused (i.e. problem solving or managing the problem's source) or emotion-focused coping (i.e. behaviors or cognitions to manage emotional distress) categories. Examples of problem-focused coping items include "Got the person responsible to change his or her mind" and "Made a plan of action and followed it." Items representing the emotion-focused coping subscale are "Accepted sympathy and understanding from someone" and "Tried to forget the whole thing." Items belonging to each subscale were summed with higher scores reflecting greater use of either problem-or-emotion-focused coping. Possible scores for each scale could range from 21 to 84.

The Cronbach's alphas reported by Folkman and Lazarus (1980) were .80 for the problem-focused coping subscale and .81 for the emotion-focused subscale. To assess the psychometric properties of Folkman and Lazarus' *Ways of Coping Checklist*, Vitaliano and colleagues (1985) conducted studies among three groups of participants: 1) Outpatients at a community mental health center; 2) spouses of patients with senile dementia; and 3) first or second year medical students. After factor analyzing the WCCL, Vitaliano and researchers identified five subscales (i.e. Problem-Focused Coping, Seeks Social Support, Blamed Self, Wishful Thinking, and Avoidance). Sample items of the Problem-Focused Coping subscale include "Accepted the next best thing to what I wanted" and "Stood my ground and fought for what I wanted." Sample items from the Seeks Social Support subscale are "Talked to someone to find out about the situation" and "Asked someone I respected for advice and followed it." Blamed Self subscale sample items are "Blamed yourself" and "Criticized or lectured yourself." Items representing the Wishful Thinking subscale are "Hoped a miracle would happen" and "Wished I could change what had happened." Sample items of the last subscale, Avoidance, include "Went on as if nothing had happened" and "Kept my feelings to myself." Vitaliano and colleagues assessed the psychometric properties of the WOCC. They found that the revised subscales had good reliability estimates among their sample of medical students: .88 for Problem-Focused Coping, .85 for Wishful Thinking, .78 for Blamed Self, .75 for Seeks Social Support, and .74 for Avoidance. In 2005, Yi, Smith, and Vitaliano found that among young women athletes, those who were considered resilient

utilized Problem-Focused Coping and Seeking Social Support, while less resilient athletes reported greater use of Blaming Others and Avoidance (consistent with emotion-focused coping). The current study used Folkman and Lazarus' (1980) conceptualization of coping as consisting of problem and emotion focused dimensions. Cronbach's alphas for the study sample were .88 for problem-focused coping and .87 for emotion-focused coping.

Interpersonal and General Mattering Assessment (IGMA). In 1991, Marcus introduced a 5-item measure to assess mattering. This scale, the *General Mattering Scale* (GMS), was developed to correspond with Fromm's (1941) conceptual framework and Rosenberg and McCullough's (1981) two forms of mattering (i.e. interpersonal and general/societal mattering). The items included: 1) "How important do you feel you are to other people?" 2) "How much do you feel other people pay attention to you?" 3) "How much do you feel others would miss you if you went away?" 4) "How interested are people generally in what you have to say?" and 5) "How much do people depend on you?" Using this five-item GMS scale, DeForge and Barclay (1997) reported an internal consistency of .85 for a sample of 199 homeless men. Connelly and Myers (2003) factor analyzed the GMS scale and found that the item "How much do you feel others depend on you?" did not contribute to the factor structure. After deleting this item, their internal consistency was .86. In contrast, Schieman and Taylor (2001) reported an internal consistency of .78 and that all five items loaded on one factor; however, the "How much do you feel others depend on you?" item had the weakest loading.

Studying factors related to wellness, Dixon Rayle and Myers (2004) administered the GMS and the *Mattering to Others Questionnaire* (MTOQ; Marshall, 1998; 2001) to 462 adolescents and reported Cronbach's alphas of .73 for minority adolescents and .74 for all participants for the GMS. In 2004, Dixon Rayle created a 30-item assessment of mattering, the *Interpersonal and General Mattering Assessment* (IGMA), which examined perceived mattering to mother, father, children, significant other, friends, society, school/workplace, and home community. Examining gender, Dixon Rayle (2006b) reported Cronbach's alphas of .73 for male and .75 for female adolescents for the IGMA and provided evidence of construct validity by correlating it with MTOQ scores for perceived mattering to "family." In 2007, Dixon Rayle and Chung administered a 14-item version of the IGMA to university students and found that college friend social support was the greatest predictor of mattering and that the most powerful predictor of academic stress was mattering to the college. The Cronbach's alphas for the mattering to college friends and to college subscales were .94 and .93, respectively.

In 2005, Dixon Rayle further modified the IGMA to assess perceived mattering to friends (five items) and mattering to parents (four items). Dixon and Robinson Kurpius (2009) administered the nine-item IGMA (IGMA-9) to undergraduates in Educational Psychology courses and then re-administered it two weeks later. The test-retest reliability for the total scale was .76, and the Cronbach's alpha for testing one was .82 and was .86 for testing two. For just the four mattering to parents items, the test-retest reliability was .80 with Cronbach's

alphas of .70 for testing one and .68 for testing two. The test-retest reliability for the five mattering to friends items was .69, with Cronbach's alphas of .86 for testing one and .87 for testing two. These data provide evidence of score reliability.

In two separate studies, Dixon and Robinson Kurpius (2008; 2009) assessed the relationship of perceived mattering (IGMA-9; Dixon Rayle, 2005) to attachment to mother and to father (*Parent and Peer Influence Scales*, IPPS; Procidano & Heller, 1983) in Study One and to mother, father, and friends in Study Two. The Cronbach's alphas were .79 and .80 for general mattering, .63 and .66 for mattering to parents, and .88 and .89 for mattering to friends. Both attachment to mother and attachment to father were consistently correlated with general mattering, mattering to mother, and mattering to father. Mattering to friends had a weaker but significant relationship with attachment to mother and to father ($r = .18$, $p < .002$). For Study Two, general mattering and mattering to friends were positively correlated with attachment to friends ($r = .61$, $p < .001$ and $r = .69$, $p < .001$, respectively). In Study One, general mattering was also positively correlated with self-esteem. These data support the convergent validity of mattering with respect to mother and father attachment, friend attachment, and self-esteem.

The reported internal consistency reliability of the IGMA-9 (Dixon Rayle, 2005) varies from .73 to .89. Evidence supporting validity is limited and has been provided indirectly through research examining related outcome variables such as job satisfaction (Dixon Rayle & Meyers, 2004), self-esteem (Dixon, Robinson

Kurpius, Weber, & Carr-Jordan, 2007; Marshall, 2001), depression (Taylor & Turner, 2001), and job related stress (Dixon Rayle, 2006a). For this study, Cronbach's alphas for the nine-item general mattering scale was .85, mattering to parents (5 items) was .84, and mattering to friends (four items) was .87.

Procedures

Data were collected from the community agency during the summer and fall of 2009. Agency staff recruited students from academic and life skills courses and from residential living. Participants who agreed to be involved in the study completed an anonymous survey packet during a scheduled meeting time. The survey packet took 20 to 30 minutes to complete. All data was anonymous and stored in a locked cabinet in a locked faculty office. The response rate was approximately 86%. Not all participants completed every instrument so cell sizes varied according to instruments completed.

Chapter 3

Results

Prior to analyzing the study hypotheses, the internal consistencies for each of the outcome variables were calculated. These are reported in the instrumentation section. In addition, the distributions of scores were examined to determine normalcy. Based on responses to the *Early Sexual Experiences Checklist* (ESEC; Miller, Johnson, & Johnson, 1991), participants were categorized into two groups, those who had experienced childhood sexual abuse (n = 77) and those who had not experienced childhood sexual abuse (n = 109), to test several of the hypotheses. Seventy-three participants did not respond or did not answer all the questions on the ESEC. The overall means and standard deviations as well group means and standard deviations for each of the outcome variables are presented in Table 2.

The first hypothesis predicted that participants who experienced childhood sexual abuse (CSA) would have poorer attachment to father and to mother as well as less mattering to parents compared to participants who did not experience CSA. To test this hypothesis, a multivariate analysis of variance (MANOVA) was first conducted using attachment to mother and attachment to father to compare the two groups. Significant multivariate group differences were found, Wilks' Lambda F (2, 165) = 3.39, p = .036, η^2 = .040. Follow-up analyses of variance (ANOVA) revealed differences in attachment to father, F (1, 166) = 5.08, p = .026, η^2 = .030, but not attachment to mother, F (1, 166) = 3.13, p = .079, η^2 = .018. CSA survivors had significantly lower attachment to their fathers

Table 2

Group Means for Attachment, Mattering, Coping, and Childhood Sexual Abuse Variables

	Survivors				Not Abused	
Total Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*
Attachment to Mother	3.60	(.83)	3.80	(.77)	3.71	(.80)
Attachment to Father	2.82	(.91)	3.14	(.83)	3.01	(.87)
Attachment to Friends	3.80	(.76)	3.77	(.68)	3.76	(.71)
Mattering to Parents	3.14	(.76)	3.40	(.53)	3.30	(.70)
Mattering to Friends	3.20	(.64)	3.20	(.80)	3.20	(.71)
Emotion Focused Coping	58.90	(9.80)	57.60	(11.10)	58.16	(10.50)
Problem Focused Coping	61.40	(8.83)	63.02	(9.50)	62.30	(9.22)
Negative Impact	8.20	(4.50)				
Force	2.80	(2.80)				
Severity	4.70	(2.94)				
Duration (Number of times)	2.60	(1.21)				
Duration (How long)	2.33	(1.20)				

(*M* = 2.74, *SD* = .92) than did participants who were not abused (*M* = 3.07, *SD* = .89). Regardless of abuse history, all participants reported higher attachment to their mothers (*M* = 3.64, *SD* = .88) than to their fathers (*M* = 2.95, *SD* = .92). An

ANOVA conducted to compare the two groups on perceived mattering to parents also revealed group difference, F (1, 186) = 4.02, p = .046. Participants who experienced childhood sexual abuse (M = 3.02, SD = .86) perceived that they mattered less to their parents than those who were not survivors (M = 3.25, SD = .72). These data support hypothesis one.

The second hypothesis, which predicted that participants with a history of childhood sexual abuse would report less attachment and mattering to friends than would participants without a history of childhood sexual abuse, was tested with a MANOVA. No differences were found, Wilks' Lambda $F < 1.00$. Therefore, hypothesis two was not supported by the data.

A MANOVA was also used to test hypothesis three: Participants with a history of childhood sexual abuse would report more emotion-focused and less problem-focused coping than would participants who reported no history of childhood sexual abuse. When both emotion-and-problem-focused coping were used as the dependent variables, the Wilks' Lambda F failed to reach significance, F (2, 180) = 2.31, p = .10.

When male and female survivors of childhood sexual abuse were compared on emotion-focused coping and problem-focused coping to test hypothesis four, significant multivariate group differences were found, Wilks' Lambda F (2, 71) = 3.29, p = .043, η^2 = .085. Follow-up analyses of variance (ANOVA) revealed differences in gender for problem-focused coping, F (1, 72) = 6.57, p = .012, η^2 = .084, but not in emotion-focused coping, F (1, 72) = 1.88, p = .175, η^2 = .025. Male survivors of childhood sexual abuse (M = 58.01, SD = 8.70) used

significantly less problem-focused coping than did the female survivors of childhood sexual abuse (M = 63.28, SD = 8.42) (see Table 3). Therefore, hypothesis four was not supported.

It was expected that female survivors of childhood sexual abuse would report a greater negative impact of the abuse than would male survivors (H5). The 46 females who reported childhood sexual abuse were compared on the bothersome subscale to the 31 males who reported childhood sexual abuse. Significant gender differences were found, F (1, 67) = 13.18, p = .001, η^2 = .164. As expected, women (M = 9.39, SD = 4.31) reported that the childhood sexual abuse had a greater negative impact than did the men (M = 5.55, SD = 3.61) (see Table 3). Based on these data, hypothesis five was supported.

Hypothesis six proposed that more force, greater perceived severity, and longer duration of the childhood sexual abuse would be positively related to negative impact of the childhood sexual abuse. A stepwise multiple regression was used to test this hypothesis. Force, severity, and duration were entered to predict negative impact. Together force and severity were the significant predictors of perceived negative impact, R^2 = 45.3%, with force being the strongest predictor, F (1, 52) = 26.28, p = .001, alone accounting for 33.6% of the variance. Severity added 11.7% to the accounted for variance, ΔF (1, 51) = 10.90, p = .002. Together force ($ß$ = .73, t = 6.45, p = .001) and severity ($ß$ = -.37, t = -3.30, p = .002) were significant predictors. Examination of the correlations revealed that only force was significantly correlated with perceived negative

Table 3

Group Means for Gender Differences in Coping and Childhood Sexual Abuse Variables

	Male Survivors		Female Survivors		Total	
Variables	*M*	*SD*	*M*	*SD*	*M*	*SD*
Emotion Focused Coping	56.86	(8.64)	60.10	(10.26)	58.90	(9.77)
Problem Focused Coping	58.01	(8.70)	63.30	(8.42)	61.40	(8.83)
Negative Impact	6.60	(3.80)	9.13	(4.50)	8.20	(4.50)
Force	2.40	(2.92)	2.95	(2.80)	2.80	(2.80)
Severity	5.54	(2.72)	4.23	(2.98)	4.70	(2.94)
Duration (Number of times)	2.73	(1.22)	2.55	(1.22)	2.60	(1.21)
Duration (How long)	2.53	(.99)	2.24	(1.21)	2.33	(1.20)

impact, $r = .58$, $p = .001$. While force and severity were highly correlated, $r = .40$, $p = .001$, severity alone was not correlated with negative impact. Hypothesis six was partially supported.

The seventh hypothesis predicted that a history of childhood sexual abuse and attachment to mother and to father would predict coping behaviors. Two multiple regression procedures were used to test this hypothesis. First, whether or not a participant was a survivor of childhood sexual abuse (coded 1 or 0), attachment to mother, and attachment to father were entered in a stepwise regression to predict problem-focused coping. The only significant predictor of

problem-focused coping, R^2 = 11.5%, F (1, 162) = 21.13, p = .001, was attachment to mother, ß = .34, t = 4.60, p = .001. Attachment to mother was positively related to problem-focused coping, r = .34, p = .001. When these same three variables were used to predict emotion-focused coping, they failed to account for a significant portion of the variance. Hypothesis seven was partially supported.

Hypothesis eight predicted that history of childhood sexual abuse and attachment to mother and to father would predict attachment to friends. A hierarchical regression was calculated with attachment to mother and attachment to father entered in step one. They accounted for 6.1% of the variance in attachment to friends, F (2, 158) = 6.17, p = .003. The beta weights were .26, t = 3.29, p = .001, for attachment to mother and .037 (t < 1.00) for attachment to father. When whether the participant had experienced childhood sexual abuse was added as step two, it accounted for no additional variance. Based on these data, hypothesis eight was partially supported.

The last hypothesis predicted that these same three independent variables would predict mattering to parents and mattering to friends. Two hierarchical regressions were used to test this hypothesis. In the first regression equation, attachment to mother and attachment to father were entered in step one to predict mattering to parents. These two attachment variables accounted for 51% of the variance, F (2, 165) = 87.82, p = .001. Next, history of child sexual abuse was added as step two. It did not enhance the accounted for variance. Examination of the beta weights indicated that attachment to mother, β = .61, t = 10.98, p = .001,

and attachment to father, $\beta = .26$, $t = 4.71$, $p = .001$, were significant predictors of mattering to parents. The second regression equation predicted mattering to friends. The two attachment variables entered in step one, accounted for 5.8% of the variance, $F\ (2, 165) = 6.12$, $p = .003$. When sexual abuse history was added as step two, it did not enhance the accounted for variance in mattering to friends. Examination of the beta weights indicated that only attachment to mother was significant, $\beta = .24$, $t = 3.06$, $p = .003$. Based on these data, hypothesis nine was partially supported.

Chapter 4

Discussion

In 1969, Bowlby developed Attachment Theory that addresses the importance of the caregiver and child relationship. Bowlby asserted that a child's development of attachment is a normal and important aspect of social functioning. Attachment begins in infancy when children are dependent on their caregivers for survival. According to Bowlby, children develop secure attachments when their caregivers are stable, supportive, and trusting. Maladaptive attachment styles (i.e. avoidant, ambivalent, and disorganized) can arise in children with caregivers who are neglectful, abusive, or inconsistent. While this study used attachment to capture participants' perceptions of their connections with their mother and father as children, the construct of mattering examined how these young adults perceive their current relationships with their parents.

A concept related to attachment is mattering. Mattering is a self-belief and is the feeling of being needed and cared for by others (Rosenberg & McCollough, 1981). Attachment to mother and to father and mattering to parents are highly correlated constructs (Dixon & Robinson Kurpius, 2009). Research shows that young adults who reported high levels of attachment to mother and to father also believed that they mattered more to their parents (Dixon & Robinson Kurpius). Based on the importance of the child-caregiver relationship, one purpose of the current study was to explore the role of attachment and mattering for these at-risk young adults. Specifically, this study examined the differences between survivors of childhood sexual abuse and those without a history of

childhood sexual abuse in attachment to mother and to father as well as mattering to parents.

Unlike attachment, there were no studies found in the literature that examined mattering in conjunction with childhood sexual abuse. However, since mattering is correlated with attachment and self-beliefs, specifically self-esteem (Dixon & Robinson Kurpius, 2008, 2009), variables negatively impacted by childhood sexual abuse experiences, it was predicted that survivors would perceive that they were both less attached to and mattered less to their parents than those with no history of childhood sexual abuse. When attachment to mother and to father was examined, survivors reported less attachment than did non-survivors; however, post-hoc analyses revealed that the difference was due to attachment to father. When mattering was the outcome variable, survivors perceived that they mattered less to their parents than did those who had no childhood sexual abuse history.

When differences between survivors of childhood sexual abuse and participants with no history of sexual abuse were examined for attachment to mother and attachment to father, no group differences in attachment to mother were found. This result challenges Lynch and Cicchetti's (1991) findings that maltreated children and adolescents had "confused" relational patterns with their mothers as well as Putnam's (1990) theory that postulated that a history of childhood sexual abuse would undermine survivors' ability to develop a secure attachment style. Although the current study found no group differences in attachment to mother, neither the quality of the relationship with mother nor type

of attachment that had been formed was not investigated. These variables might have helped to explain the findings related to sexual abuse history and attachment to mother. This sample simply reported greater attachment to their mother/mother figure than to their father/father figure. It should be noted that this finding parallels the findings of Carr Jordan (2008) who studied undergraduates and of Kirton (2000) who studied incoming college freshmen. Both studies found that students, who were approximately the same age as participants in the study, were more attached to their mother than to their father. Taken collectively, these studies suggest that young adults are more attached to their mothers than to their fathers, regardless of other circumstances; however, scores for attachment to mother were lower for the participants in the current study as compared to those scores reported by Carr Jordan and by Kirton.

Differences were found, however, between those with a history of childhood sexual abuse and those without when attachment to father was analyzed. Those who had experienced childhood sexual abuse reported significant lower attachment to their fathers than did those young adults who had not experienced childhood sexual abuse. Fathers could have been birth father, step-father, or anyone the participant identified as a father figure. In Roche et al.'s (1999) study, female survivors reported more insecure attachment styles than those who had not been sexually abused. Furthermore, they found that those who had been perpetrated against by a family member were more insecure than those with extrafamilial childhood sexual abuse. A majority of survivors know their perpetrator at the time of abuse (National Child Abuse Statistics). Furthermore,

children living with a stepfather are at higher risk for childhood sexual abuse (Finkelhor, 1993; Weiner & Robinson Kurpius, 1995; Whetsell-Mitchell, 1995). Since sexual abuse violates a child's sense of trust and safety, survivors may have difficulties developing and maintaining satisfying interpersonal relationships (Cole & Putnam, 1992; Muller & Lemieux, 2000). Based on the literature, possible explanations for survivors in this study being less attached to their fathers (father-figures) could be that those who had been sexually abused may have had fathers who were uninvolved or absent during childhood, their fathers may have been the perpetrators of their sexual abuse, or their fathers may have been perceived as not protecting them from abusive situations. The finding regarding attachment to father being lower for sexual abuse survivors adds support to other literature on the relationship of father attachment and at-risk behaviors (Carr, 2005; Hart, 2005).

While both attachment to mother and to father are paramount in a person's development of identity and psychological well-being (Bowlby, 1969), one's relationship with one's father appears to be related to several variables. For example, stronger attachment to father is related to less relational aggression, early sexual behaviors, and drug use (e.g., Carr, 2005, Carr Jordan, 2008; Hart, 2005). Also, those with stronger attachment to father had healthier body images and greater self-esteem (e.g., Meza, 2005). Fathers play a unique role in young people's lives. Perhaps they model adaptive lifestyle behaviors and healthy relationships, set firm boundaries for behaviors, or are protective of their children.

Young people's development can be negatively affected if fathers are uninvolved, neglectful, or abusive (Bowlby) or if the fathers are perceived as being this way.

It is conceivable that these survivors of childhood sexual abuse also perceived that they mattered less to their parents because as children they felt unsafe and unprotected from the abuse or their parents failed to acknowledge the childhood sexual abuse. Growing up in uncaring and inconsistent homes coupled with the experience(s) of childhood sexual abuse can be related to these young people believing that their parents are unconcerned with their well-being. In addition, these at-risk young adults had often experienced multiple negative life and family related events, such as homelessness, getting involved in gangs in order to have a sense of family or belonging, abandonment, and various types of abuse. These young people who had experienced childhood sexual abuse, an ultimate betrayal of trust particularly if the perpetrator was a parent, carry remnants of this betrayal, and this may have translated into their lower mattering scores, which indicate that they still believe that they do not matter or are not important to their parents. The past continues to affect the way they perceive their value, particularly to their parents.

Not only do attachment and perceived mattering to parents influence the lives of young people, creating strong peer relationships is a major developmental task during this time in their lives. In his Stages of Psychosocial Development, Erikson (1959) denotes the adolescent and young adulthood years as the time for gaining autonomy from caregivers and learning about one's self through social roles. Young people in the identity and repudiation versus identity diffusion as

well as in the intimacy versus isolation stages focus on developmental tasks such as individuation, internalizing values, and forming meaningful friend and romantic relationships (Erikson). Researchers report that children's ability to develop healthy prosocial relationships is related to their parental attachment style (e.g., Bowlby, 1980; Granot & Mayseless, 2001; Sroufe et al., 1990).

Children with secure attachments demonstrate more social, emotional, and cognitive competence than those with insecure attachment styles (e.g., Ainsworth, 1989; Ainsworth et al., 1978; Belsky & Cassidy, 1994; Bowlby, 1980; Granot & Mayseless, 2001; Thompson, 1997). Unfortunately, insecure attachment to caregivers place young people at risk for developing negative models of intra-and-interpersonal relationships, for being distrustful, and/or for basing self-worth on the appraisals of others (e.g., Blain et al., 1993). Studies related to the relationship between perceptions of attachment to parents and attachment to friends report that children with insecure attachments to parents are more aggressive, have less social competence, and have problems engaging peers (e.g., Cassidy & Berlin, 1994; Fagot & Kavanagh, 1990; Granot & Mayseless, 2001; Lyons-Ruth et al., 1993). In contrast, secure attachment is associated with advantages. For example, adolescents with this attachment style are better able to respond to social challenges, such as rejection (e.g., Kosterman et al., 2004). In addition, young people with strong attachments to their parents have less relational aggression and conduct problems (e.g., Carr Jordan, 2008); they also feel that they matter more to their friends (Dixon & Robinson Kurpius, 2009).

Thus, strong attachments to mother and to father are protective factors for the development of healthy peer relationships.

Since fostering and maintaining peer relationships is crucial in the lives of young people, especially for at-risk youth who have low levels of attachment and perceived mattering to their parents, this study examined the roles of attachment to mother and to father and childhood sexual abuse on peer attachment and mattering to friends. The impact of childhood sexual abuse on peer relationships was of particular interest because research has indicated that survivors may experience interpersonal difficulties (e.g., Whetsell-Mitchell, 1995; Davis et al., 2001), such as with friend relationships. In fact, major indicators of childhood sexual abuse include social withdrawal and/or changes in interpersonal behaviors (e.g., Whetsell-Mitchell). Also, Davis' research team found that survivors of sexual abuse have problems maintaining healthy and trusting relationships.

In the current study, when those who experienced childhood sexual abuse were compared to those with no history of childhood sexual abuse, there were no differences in both mattering and attachment to friends. These findings are interesting in light of the literature suggesting that survivors of childhood sexual abuse may have problems developing and sustaining interpersonal relationships (e.g., Davis et al., 2001; Whetsell-Mitchell, 1995). To investigate further survivors' attachment to peers, a history of childhood sexual abuse was added to a hierarchical regression model with attachment to mother and to father to predict attachment to friends. It was found that a history of childhood sexual abuse did not account for significant variance. Only attachment to mother was a significant

predictor of attachment to peers among survivors of childhood sexual abuse. When a history of childhood sexual abuse and attachment to mother and to father were examined in relationship to mattering to parents and to friends among survivors, again childhood sexual abuse was not a significant predictor. Similar to attachment to friends, attachment to mother accounted for significant variance in mattering to friends. Based on the high correlation between attachment to mother and to father and mattering to parents (Dixon & Robinson Kurpius, 2009), it was not surprising that both attachment variables were significant predictors of mattering to parents among survivors of childhood sexual abuse.

A possible explanation for these findings may be related to the living situations of these participants. A majority of the sample was no longer living at home, and they spent a majority of their academic and work time with peers. Even though the literature has suggested that childhood sexual abuse experiences can disrupt the developing sense of self and thus make it more difficult for people to maintain satisfying relationships (e.g., Cole & Putnam, 1992; Muller & Lemieux, 2000), the findings in this study suggest that regardless of abuse history, these at-risk young adults felt connected to their peers. It seems that the role of friends in these participants' lives may help to counteract their previous negative life experiences, including a history of childhood sexual abuse.

In fact, researchers have found that supportive relationships help buffer the negative psychological consequences of childhood sexual abuse (e.g., Adams & Bukowski, 2007; Whiffen et al., 1999). Survivors with close peer and high quality intimate relationships were less vulnerable to sexual abuse related

symptoms (e.g., Aspelmeier, 2007; Whiffen et al.). Based on major developmental milestones, it is expected that young adults will actively engage in peer relationships (Erikson, 1959). The importance of peer relationships was supported by Hay and Ashman's (2003) research, which reported that adolescents' peer relationships impacted emotional stability more than did their relationships with parents. The current sample, especially when there are low levels of attachment to parents, may have relied on their peer relationships to obtain social support, acceptance, and positive feedback from others. These findings once again highlight the importance of the role of attachment to mother and to father in peer relationships. While all participants, regardless of childhood sexual abuse history, were attached to their friends, attachment to mother and attachment to father were related to greater attachment and mattering to friends. Participants who reported more attachment to mother and to father believed that they presently mattered more to their friends, regardless of childhood sexual abuse experiences. Particularly, the foundational relationship with mother made a difference in participants perceiving greater attachment to their peers.

Another variable of interest was coping behaviors, specifically emotion-focused and problem-focused coping. The at-risk youth in this study have experienced instability, lack of supportive relationships, and trauma. Coping was examined to learn more about how these young people respond to the challenges in their lives. In 1984, Lazarus and Folkman began to research how people use cognitive and behavioral resources to respond to experiences perceived as straining. These researchers hypothesized that the level of threat associated with

a stressor and one's perceived amount of control in response to the situation affects the selection of coping strategies. When people are faced with multiple stressors, maladaptive coping strategies may be used due to depleted personal resources (e.g., Baumeister et al., 1999; Hobfoll et al., 1996).

Lazarus and Folkman (1984) developed two major categories of coping: 1) emotion-focused coping and 2) problem-focused coping. Emotion-focused coping strategies can be used to manage emotions and can include self-blame and avoidance. Utilizing behaviors, such as seeking social support and developing a plan, to address a stressful situation were associated with problem-focused coping. These researchers predicted that emotion-focused coping versus problem-focused coping can be used when people perceive the stressful experience to be out of their control. Since the experience of childhood sexual abuse is a highly stressful event and out of a child's control, it was predicted that survivors would engage more emotion-focused coping and less problem-focused coping compared to those with no history of childhood sexual abuse (e.g., Leitenberg et al., 2004).

This study found that there were no differences between survivors and those with no history of childhood sexual abuse in emotion-focused coping and in problem-focused coping. This finding contradicts studies that report sexual abuse being significantly related to the use of emotion-focused coping strategies (e.g., Brand & Alexander, 2003). Emotion-focused coping is associated with negative psychological outcomes among survivors (e.g., Gibson & Leitenberg, 2001; Leitenberg et al., 1992; Spaccarelli, 1994). For example, higher levels of distress are associated with the use of avoidance coping, a type of emotion-focused

coping, among survivors of incest (Johnson & Kenkel, 1991). Studies also show that survivors of sexual abuse rarely engage in problem-focused coping (e.g., Brand & Alexander; Herman, 1992). The current findings do not support these previous studies. It is possible that the participants in this study have had to learn to be problem-focused in order to survive to survive in their daily lives. As noted previously, these young people most likely had experienced many traumatic events and perhaps the fact they were all trying to learn skills in order to obtain semi-skilled jobs indicates that they were using problem-focused coping in their lives.

Research has suggested that male survivors of sexual abuse may be more likely than female survivors to use problem-focused coping (e.g., Rosario et al., 1988; Ullman & Filipas, 2005). Therefore, gender differences in coping styles among sexual abuse survivors were examined. There were no differences in use of emotion-focused coping. Although research has shown that female survivors compared to male survivors utilize more emotion-focused coping (e.g., Lewis, 1992; Tangney, 1991), this was not supported by the current study. Both males and females used more problem-focused than emotion-focused coping. Perhaps these young people, both men and women, have learned to try to solve their problems rather than just emote over them. When gender differences were examined among problem-focused coping, female survivors of childhood sexual abuse used more problem-focused coping than did the male survivors. These findings contradict studies currently in the literature that men may use more problem-focused coping being they are socialized to be more active and self-

reliant (e.g., Rosario et al., 1988). In addition, men are socialized to manage stress more instrumentally, while women tend to express more emotion in response to stress (e.g., Rosario et al). Female survivors in this study may use more problem-focused coping than did the male survivors of childhood sexual abuse due their life circumstances requiring them to find solutions or seek support for their stressors. These at-risk young women were often responsible for caring for younger siblings and/or children of their own. Also, women in this sample often had to balance work and academic obligations with family considerations. Perhaps the high level of responsibility these female survivors experience has necessitated them learning problem-focused coping skills.

In order to learn more about factors that make a difference in survivors of childhood sexual abuse using problem-focused coping versus emotion-focus coping, this study examined the role of attachment to mother and to father to coping. The literature suggests that children who develop insecure attachment styles often have poor emotional regulation and engage in maladaptive intra-and-interpersonal behaviors, such as low self-esteem and being aggressive (e.g., Barber, 1992; Barnow et al., 2005; Bowlby, 1969; Fagot & Kavanagh, 1990; Granot & Mayseless; 2001; Lyons et al., 1993). People with insecure attachment to caregivers may develop negative working models and maladaptive coping styles, such as detached and avoidant coping (e.g., Shapiro & Levendosky, 1999).

When a history of childhood sexual abuse and attachment to mother and to father were used to predict problem-focused coping, attachment to mother was the only significant predictor of this coping style. None of these variables predicted

emotion-focused coping. These findings suggest that a strong relationship with mother makes a difference in survivors' ability to engage in effective coping strategies, specifically problem-focused coping. This finding reaffirms the important role the mother plays in the life of these young people. It also supports earlier findings regarding attachment to father being weak or not being particularly relevant to these young adults.

Upon examining this study's results regarding coping, there are a few possibilities to explain the first finding of a lack of difference in coping strategies used among survivors of childhood sexual abuse and those with no history of childhood sexual. Regardless of childhood sexual abuse experiences, many of these at-risk young people have been forced to be independent and survive on their own. Participants in this sample often lacked family involvement, financial resources, and social support. Also, these young people are different from other young adults in this age range in that they often began working at a young age to help financially support their parents and siblings, had taken leadership roles in gangs for survival, and/or had lived with multiple caregivers or on their own during their childhood and adolescent years.

Even though traumatic experiences were associated with a greater utilization of emotion-focused coping, perhaps the implementation of problem-focused coping was necessary for these survivors of childhood sexual abuse, particularly the females, to find resources, such as employment and shelter. This at-risk sample was proactive and may have engaged a plan to access the resources at the community agency where they resided. Also, perhaps the resources at the

community agency, such as mental health services, helped provide these young people with more problem-focused coping strategies. For survivors of childhood sexual abuse in this study, a strong attachment to mother was related to the use of problem-focused coping. Perhaps having a caring and involved mother has modeled adaptive coping skill strategies and has provided a sense of support and safety for these survivors.

In addition to comparing the variables of attachment, mattering, and coping among survivors of childhood sexual abuse and those with no history of childhood sexual abuse, this study examined factors related to perceived negative impact of the childhood sexual abuse among survivors. Researchers have found that abuse-related variables, including the duration of the childhood sexual abuse, frequency of the abuse, and severity of the abuse (i.e. defined as the number of childhood sexual abuse incidents one experiences), affect survivors' perceptions of the childhood sexual abuse (Long-Term Consequences, 2006; Weiner & Robinson Kurpius, 1995). However, these factors need to be studied further as some researchers have not found these variables to be significant in predicting their outcome variables. For example, Beasley (1997) reported that the use of force, penetration, and the duration of childhood sexual abuse were not related to her study's outcome variables, such as depression and anxiety.

Kendall-Tackett et al.'s (1993) analysis, however, of 45 childhood sexual abuse studies reported that a high frequency of sexual abuse, longer duration of abuse, and coercion were predictive of increased symptomatology among survivors. Survivors of sexual abuse in the analyzed studies reported problems

that included depression, aggression, and fear. To learn more about factors associated with a perceived negative impact of childhood sexual abuse, this study examined force, perceived severity of childhood sexual abuse, and the duration of the childhood sexual abuse experience. More force, which included behaviors such as perpetrator's verbal threats or use of physical restraint during the abuse, and greater severity (i.e., a larger number of sexual abuse experiences) were associated with survivors perceiving the childhood sexual abuse experience(s) more negatively. Duration of the abuse did not predict survivors' experiencing a greater negative impact of the childhood sexual abuse. These results suggest that even one incident of childhood sexual abuse with more force and greater perceived severity can be perceived as highly negative, thus placing a survivor at risk for psychological, relationship, behavioral, and other problems. For example, Paolucci's (2001) meta-analysis reported that childhood sexual abuse was positively related to PTSD, depression, suicide, problems with academic achievement, and at-risk sexual behavior.

This study also examined whether men and women differed in their reported negative impact of being sexually abused as children. A majority of studies have focused only on female survivors (e.g., Banyard et al., 2004; Holmes, 1998), thus not as much information is known regarding the effects of childhood sexual abuse on men. Of the research that is available, female survivors of sexual abuse, as compared to male survivors, have reported greater negative effects, such as more depression and anxiety (Banyard et al.), and heightened problems in response to the abuse, such as greater feelings of vulnerability, perceiving the

world as dangerous, and sexual anxiety (Feiring et al., 1999). This study also found that female survivors reported a greater negative impact of their childhood sexual abuse than did the male survivors. Female survivors may have perceived their childhood sexual abuse experiences as more negative because more force was involved or they felt more targeted for the abuse. Also, based on traditional gender roles, women more than men, may feel guilty and blame themselves for the abuse. As it is more socially acceptable for men to be sexually active, perhaps men perceived their childhood sexual abuse as less damaging to their identity development.

Limitations

While the findings of this study make a significant contribution to the knowledge about regarding childhood sexual abuse, there are limitations that need to be noted. The three main areas of limitations are related to sampling, study design, and measurement. Regarding sampling, the population selected for this study was not a general population. Participants were at-risk young adults with a multitude of traumatic events in their lives. In addition to many participants being survivors of childhood sexual abuse, they may also have experienced trauma that included physical or emotional abuse, neglect, homelessness, overcrowding in the home, and gang violence. Traumatic experiences in addition to childhood sexual abuse may have effected how participants answered questions regarding their attachment and mattering to parents and friends, coping, and childhood sexual abuse history.

This study utilized a cross sectional design, and participants completed the questionnaires using paper and pens. Due to the nature of a cross sectional study, there were no research strategies (i.e. in depth interviews) used to explore participants' childhood sexual abuse history more in depth. Important information, such as childhood development, the impact of various traumatic events on participants' perceptions of their childhood sexual abuse experiences, and home life, that would enhance understanding of the variables in this study were not gathered. In addition, this study was retrospective in nature and therefore did not measure what actually happened regarding participants' childhood sexual abuse incidents. Recounts of childhood sexual abuse were based on memory; the childhood sexual abuse experiences may have been better or worse than what was reported. Answering questions about childhood sexual abuse can be distressing which may explain why several participants did not complete this questionnaire. Incomplete data may have resulted in this study missing critical information about this sample's childhood sexual abuse experiences. Once again, gathering more qualitative research may have enhanced this study's ability to better understand the perspectives, experiences, and reactions the participants had to the measures and variable explored in this study.

When considering measurement implications, the attachment to mother, to father, and to peer questionnaires may have not been the most effective measures to use. While the attachment surveys obtain information regarding the influence of attachment in participants' lives, they did not measure specific types of attachment (i.e. secure, avoidant, ambivalent, disorganized). In addition, the

Early Sexual Experiences Checklist (ESEC; Miller et al., 1991) assisted this study in capturing whether or not many participants had a childhood sexual abuse history. Due to the personal and stressful nature of recounting childhood sexual abuse, information regarding this experience can be challenging to research. However, the ESEC could have been stronger by having additional childhood sexual abuse experiences questions that explored more in the areas of perpetrator demographics (i.e. more information regarding who the perpetrator was and his or her relationship to the survivor) and home life (i.e. who was in the home at the time of the abuse).

Conclusions and Implications

Clearly childhood sexual abuse should not be part of the human experience. This at-risk sample, particularly the female survivors, reported that their childhood sexual abuse experiences were perceived as hurtful. The more force and the greater number of childhood sexual abuse incidents experienced by a survivor were related to the childhood sexual abuse having a greater negative impact on their lives. Childhood sexual abuse takes away feelings of safety, trust, and respect (e.g., Weiner & Robinson Kurpius, 1995). For this sample, childhood sexual abuse was a prevalent experience. In addition to the other struggles these young people were experiencing, they also had to cope with childhood sexual abuse. While there were no overall differences in problem-focused coping versus-emotion focused coping in this sample, female survivors of childhood sexual abuse utilized more problem-focused coping than did the male survivors. This study demonstrated that childhood sexual abuse and relationships

(attachment and mattering) to mother and to father were important factors related to coping and peer relationships, which are crucial aspects of personal identity and social development in young adults (Erikson, 1959).

All participants, regardless of childhood sexual abuse history, reported higher attachment to their mothers than to their fathers. Survivors of childhood sexual abuse believed they mattered less to their parents than those with no history of abuse. In addition, the role of mother was salient among participants. Survivors also had lower attachment to their fathers than to their mothers, and the young adults with stronger attachment to mother believed they mattered more to their friends. Attachment to mother was also important because it predicted problem-focused coping among survivors of childhood sexual abuse. These results highlight the importance of attachment to caregivers in developing peer attachment and a sense of mattering to friends, problem-focused coping skills, and perceiving childhood sexual abuse as having a less negative impact on their lives.

Counseling psychologists can consider implementing the findings in this study in several ways. Perhaps educational programs can be developed for parents of young children. Based on the importance of parental attachment, parents could benefit from learning parenting skills, such as open communication, active listening, and recognizing signs of childhood sexual abuse. Parents can also benefit from understanding how counseling can assist their family in improving family dynamics and mental health concerns.

For children and young adults who have developed insecure attachment to caregivers, counseling can provide an opportunity for these young people to experience a trusting, reliable, and caring relationship. The intra-and-interpersonal skills youth can learn in counseling can be transferred to other relationships in their lives. Counselors can assist both parents and young people in accessing community resources and enhancing healthy social support. Counseling psychologists can also help parents and their children develop adaptive, problem-focused coping strategies so they can better manage and respond to stressors and traumatic experiences in their lives.

To provide the best client care, counseling psychologists should obtain specific training in counseling survivors of abuse, specifically childhood sexual abuse. This study indicated that childhood sexual abuse is a prevalent problem, especially among at-risk young adults. Childhood sexual abuse is a traumatic experience that is often comorbid with other factors, such as at-risk drug and/or sexual behaviors, mental health problems, and maladaptive coping. Many survivors may be hesitant to discuss their abuse experiences due to painful memories, self-blame, or embarrassment. Due to the intersection of many personal beliefs and behaviors with childhood sexual abuse, it is imperative that counseling psychologists are comfortable talking about childhood sexual abuse and are properly trained to provide empirically validated interventions.

To assist counselors in providing effective counseling services to at-risk youth, including those with childhood sexual abuse histories, additional research is needed. The literature would be stronger by including more studies that

examine specific attachment related factors and styles among at-risk young adults and how these relate to other aspects of their lives, such as coping. Additional research on childhood sexual abuse would also benefit the psychology field. Studies that learn more about the participant-perpetrator relationship, family factors that place children at risk for sexual abuse, and gender differences are just a few suggestions for future research.

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APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL

ASU ARIZONA STATE UNIVERSITY
RESEARCH AND ECONOMIC AFFAIRS

Office of Research Integrity and Assurance

To:	Sharon Kurpius EDB
From:	Mark Roosa, Chair Soc Beh IRB
Date:	06/10/2009
Committee Action:	**Exemption Granted**
IRB Action Date:	06/10/2009
IRB Protocol #:	0905004056
Study Title:	A History of Childhood Sexual Abuse and Parental Attachment's Relationship to Peer Relationships and Coping

The above-referenced protocol is considered exempt after review by the Institutional Review Board pursuant to Federal regulations, 45 CFR Part 46.101(b)(2) .

This part of the federal regulations requires that the information be recorded by investigators in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects. It is necessary that the information obtained not be such that if disclosed outside the research, it could reasonably place the subjects at risk of criminal or civil liability, or be damaging to the subjects' financial standing, employability, or reputation.

You should retain a copy of this letter for your records.

APPENDIX B

INFORMED CONSENT LETTER

Dear Student,

I am a faculty member in the College of Education at Arizona State University and am interested in issues that influence students' relationships with their peers. Your participation will involve 20 to 30 minutes of your time during a scheduled meeting time to fill out a survey packet. Your name and any identification information is not being asked, so your answers are anonymous. You must be at least 18 years of age or older to participate.

Your participation is voluntary and has no influence on your academic or work performances. If you choose to skip questions, not to participate, or to withdraw at any time, you may do so. Again, your name will not be used in any way. The results of this study may be used in reports, presentations, or publications, but in no way will you personally be identified.

There are no foreseeable risks or discomforts to your participation other than remembering bothersome experiences you had as a child. Although there may be no direct benefit to you, the possible benefit of your participation could be increased awareness of how therapists can provide better mental health services to you and other students.

If you have any questions concerning this research study, please call me at 480-965-6104. If you have any questions about your rights as a participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

By filling out the questionnaire, you consent to participate in the above described study.

Sincerely,

Sharon E. Robinson Kurpius, Ph.D.
Professor of Counseling and Counseling Psychology

APPENDIX C

DEMOGRAPHICS FOR SURVIVORS AND THOSE NOT ABUSED

Background Information

Gender: M ____ F ____ Age: _____

Self identification: Latino ____ Asian American ____ Pacific Islander ____
African American ____ White ____ Native American ____
International ____ Biracial ____ Tribe_____
Other (please specify)_____

Marital status: Single ____ Married____ Divorced/Separated____
Living in a committed relationship ____

What is your highest level of completed education?
Some grade school ____ 8th grade ____
High school/GED ____ Some college or technical training ____

Current residence: Non-Resident ____ Resident ____

Religious affiliation: Catholic ____ Protestant ____ Mormon ____ Jewish ____
None ____ Agnostic ____ Atheist ____ Wicca ____
Muslim ____ Spiritual ____ Other (please specify)_____

What is your sexual orientation? Heterosexual __ Bisexual __ Gay __ Lesbian __

Who did you primarily grow up with?
Mother & father together ____ Mother only ____
Father only ____ Mother & step-father ____
Father and step-mother ____ Grandparents ____
Foster parents ____ Other (please specify): _____

Do you plan to attend college in the future? Yes____ No____ Don't know____

What is your mother's highest level of completed education?
Some grade school ____ 2 year college ____
8th grade ____ College degree ____
High school/GED ____ Master's degree ____
Some college or technical training ____ Doctoral degree ____

What is your father's highest level of completed education?
Some grade school ____ 2 year college ____
8th grade ____ College degree ____
High school/GED ____ Master's degree ____
Some college or technical training ____ Doctoral degree ____

Parental yearly income: $1 - 14,999 ____ $45,000 - 59,999 ____
$15,000 - 29,999 ____ $60,000 - $74,000 ___
$30,000 - 44,999 ____ $75,000 or more ____

Have you ever been a member of a gang? Yes____ No____

Has your mother ever been a member of a gang? Yes___ No___ Don't know___

Has your father ever been a member of a gang? Yes___ No___ Don't know___

APPENDIX D

STUDY INSTRUMENTS

Relationship with Mother

Each of the following statements asks about your feelings about your *mother*, or *mother figure*. The next page asks about your *father*, or *father figure*. Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
1. My mother respects my feelings.	1	2	3	4	5
2. I feel my mother does a good job as my mother.	1	2	3	4	5
3. I wish I had a different mother.	1	2	3	4	5
4. My mother accepts me as I am.	1	2	3	4	5
5. I like to get my mother's point of view on things I'm concerned about.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my mother.	1	2	3	4	5
7. My mother can tell when I'm upset about something.	1	2	3	4	5
8. Talking over my problems with my mother makes me feel ashamed/foolish.	1	2	3	4	5
9. My mother expects too much from me.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
10. I get upset easily around my mother.	1	2	3	4	5
11. I get upset a lot more than my mother knows about.	1	2	3	4	5
12. When we discuss things, my mother cares about my point of view.	1	2	3	4	5
13. My mother trusts my judgment.	1	2	3	4	5
14. My mother has her own problems, so I don't bother her with mine.	1	2	3	4	5
15. My mother helps me to understand myself better.	1	2	3	4	5
16. I tell my mother about my problems and troubles.	1	2	3	4	5
17. I feel angry with my mother.	1	2	3	4	5
18. I don't get much attention from my mother.	1	2	3	4	5
19. My mother helps me to talk about my difficulties.	1	2	3	4	5
20. My mother understands me.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
21. When I'm angry about something, my mother tries to be understanding.	1	2	3	4	5
22. I trust my mother.	1	2	3	4	5
23. My mother doesn't understand what I'm going through these days.	1	2	3	4	5
24. I can count on my mother when I need to get something off my chest.	1	2	3	4	5
25. If my mother knows something is bothering me, she asks me about it.	1	2	3	4	5

Relationship with Father

This part asks about your feeling about your *father*, or *father figure*. Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
1. My father respects my feelings.	1	2	3	4	5
2. I feel my father does a good job as my father.	1	2	3	4	5
3. I wish I had a different father.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
4. My father accepts me as I am.	1	2	3	4	5
5. I like to get my father's point of view on things I'm concerned about.	1	2	3	4	5
6. I feel it's no use letting my feelings show around my father.	1	2	3	4	5
7. My father can tell when I'm upset about something.	1	2	3	4	5
8. Talking over my problems with my father makes me feel ashamed/foolish.	1	2	3	4	5
9. My father expects too much from me.	1	2	3	4	5
10. I get upset easily around my father.	1	2	3	4	5
11. I get upset a lot more than my father knows about.	1	2	3	4	5
12. When we discuss things, my father cares about my point of view.	1	2	3	4	5
13. My father trusts my judgment.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
14. My father has his own problems, so I don't bother him with mine.	1	2	3	4	5
15. My father helps me to understand myself better.	1	2	3	4	5
16. I tell my father about my problems and troubles.	1	2	3	4	5
17. I feel angry with my father.	1	2	3	4	5
18. I don't get much attention from my father.	1	2	3	4	5
19. My father helps me to talk about my difficulties.	1	2	3	4	5
20. My father understands me.	1	2	3	4	5
21. When I'm angry about something, my father tries to be understanding.	1	2	3	4	5
22. I trust my father.	1	2	3	4	5
23. My father doesn't understand what I'm going through these days.	1	2	3	4	5
24. I can count on my father when I need to get something off my chest.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
25. If my father knows something is bothering me, he asks me about it.	1	2	3	4	5

Relationships with Close Friends

This part asks about your feelings about your relationships with your close friends. Please read each statement and circle the ONE number that tells how true the statement is for you now.

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
1. I like to get my friends' point of view on things I'm concerned about.	1	2	3	4	5
2. My friends can tell when I'm upset about something.	1	2	3	4	5
3. When we discuss things, my friends care about my point of view.	1	2	3	4	5
4. My friends accept me as I am.	1	2	3	4	5
5. I wish I had different friends.	1	2	3	4	5
6. My friends understand me.	1	2	3	4	5
7. My friends help me to talk about my difficulties.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
8. My friends accept me as I am.	1	2	3	4	5
9. I feel the need to be in touch with my friends more often.	1	2	3	4	5
10. My friends don't understand what I'm going through these days.	1	2	3	4	5
11. I feel alone or apart when I'm with my friends.	1	2	3	4	5
12. My friends listen to what I have to say.	1	2	3	4	5
13. I feel my friends are good friends.	1	2	3	4	5
14. My friends are fairly easy to talk to.	1	2	3	4	5
15. When I am angry about something, my friends try to be understanding.	1	2	3	4	5
16. My friends help me to understand myself better.	1	2	3	4	5
17. My friends care about how I am.	1	2	3	4	5
18. I feel angry with my friends.	1	2	3	4	5

	Almost never or never true	Not very often true	Some-times true	Often true	Almost always or always true
19. I can count on my when I need to get something off my chest.	1	2	3	4	5
20. I trust my friends.	1	2	3	4	5
21. My friends respect. my feelings.	1	2	3	4	5
22. I get upset a lot more than my friends know about.	1	2	3	4	5
23. It seems as if my friends are irritated with me for no reason.	1	2	3	4	5
24. I can tell my friends about my problems and troubles.	1	2	3	4	5
25. If my friends knows something is bothering me, they ask me about it.	1	2	3	4	5

The items below represent ways that you may have dealt with significant stressors in your life (failing a class, roommate difficulties, moving, end of a relationship, job loss, death in family, etc.). Please indicate the degree to which you usually **use** the following thoughts or behaviors in dealing with stressors in your life.

1=Never Used 2=Rarely Used 3=Sometimes Used 4=Regularly Used

	Never			Regularly
1. Changed or grew as a person in a good way.	1	2	3	4
2. Blamed yourself.	1	2	3	4
3. Hoped a miracle would happen**.**	1	2	3	4
4. Went on as if nothing had happened.	1	2	3	4
5. Concentrated on something good that could come out of the whole thing.	1	2	3	4
6. Criticized or lectured yourself.	1	2	3	4
7. Wished you were a stronger person-more optimistic and forceful	1	2	3	4
8. Felt bad that you couldn't avoid the problem.	1	2	3	4
9. Tried not to burn your bridges but left things open somewhat.	1	2	3	4
10. Talked to someone who could do something about the problem**.**	1	2	3	4
11. Realized you brought the problem on yourself.	1	2	3	4
12. Wished that you could change what had happened**.**	1	2	3	4
13. Kept your feelings to yourself.	1	2	3	4
14. Bargained or compromised to get something positive from the situation.	1	2	3	4
15. Wished you could change the way you felt**.**	1	2	3	4
16. Slept more than usual.	1	2	3	4

1=Never Used 2=Rarely Used 3=Sometimes Used 4=Regularly Used

	Never			Regularly
17. Made a plan of action and followed it.	1	2	3	4
18. Tried to forget the whole thing.	1	2	3	4
19. Daydreamed or imagined a better time or place than the one you were in.	1	2	3	4
20. Accepted the next best thing to what you wanted.	1	2	3	4
21. Had fantasies or wishes about how things might turn out.	1	2	3	4
22. Tried to make yourself feel better by eating, drinking, or smoking.	1	2	3	4
23. Came out of the experience better than when you went in.	1	2	3	4
24. Thought about fantastic or unreal things that made you feel better.	1	2	3	4
25. Avoided being with people in general.	1	2	3	4
26. Tried not to act too hastily or follow your own hunch.	1	2	3	4
27. Kept others from knowing how bad things were.	1	2	3	4
28. Changed something so things would turn out all right.	1	2	3	4
29. Talked to someone to find out about the situation.	1	2	3	4
30. Just took things one step at a time.	1	2	3	4
31. Wished the situation would go away or somehow be finished.	1	2	3	4
32. Stood your ground and fought for what you wanted.	1	2	3	4
33. Talked to someone about how you were feeling.	1	2	3	4
34. Refused to believe it had happened.	1	2	3	4
35. Accepted sympathy and understanding from someone.	1	2	3	4

1=Never Used 2=Rarely Used 3=Sometimes Used 4=Regularly Used

	Never			Regularly
36. Got professional help and did what they recommended.	1	2	3	4
37. You knew what had to be done, so you doubled your efforts and tried harder to make things work.	1	2	3	4
38. Came up with a couple of different solutions to the problem.	1	2	3	4
39. Asked someone you respected for advice and followed it.	1	2	3	4
40. Changed something about yourself so you could deal with the situation better.	1	2	3	4
41. Got mad at the people or things that had caused the problem.	1	2	3	4
42. Accepted your strong feelings, but didn't let them interfere.	1	2	3	4

This part asks about your feelings about your relationships with your parents and close friends. Please read each statement and circle ONE answer that tells how true the statement is for you now.

1. How important do you feel you are to your parents?	very much	somewhat	a little	not at all
2. How much do you feel your parents pay attention to you?	very much	somewhat	a little	not at all
3. How interested are your parents in what you have to say?	very much	somewhat	a little	not at all
4. How much do your parents depend on you?	very much	somewhat	a little	not at all

Please read each statement and circle ONE answer that tells how true the statement is for you now.

5. How important do you feel you are to your friends?	very much	somewhat	a little	not at all
6. How much do you feel these friends pay attention to you?	very much	somewhat	a little	not at all
7. How much do you feel these friends would miss you if you went away?	very much	somewhat	a little	not at all
8. How interested are your friends in what you have to say?	very much	somewhat	a little	not at all
9. How much do your friends depend on you?	very much	somewhat	a little	not at all

Bothersome Abuse Experiences

Your sex:_____ Male_____ Female

When you were under the age of eighteen (18), did any of theses incidents ever happen to you when you <u>did not</u> want them to?

Please check those that occurred:
_____ 1. Another person showed his or her sex organs to you.
_____ 2. You showed your sex organs to another person at his or her request.
_____ 3. Someone touched or fondled your sex organs.
_____ 4. You touched or fondled another person's sex organs at his or her request.
_____ 5. Another person had sexual intercourse with you.
_____ 6. Another person performed oral sex on you.
_____ 7. You performed oral sex on another person.
_____ 8. Someone told you to engage in sexual activity so that he or she could watch.
_____ 9. You engaged in anal sex with another person.
_____ 10. Other (please specify): _____.
_____ None of these events ever occurred.

If any of these above incidents ever happened to you, please answer the following questions by *thinking about the one behavior that bothered you the most.*

1. From the incidents above, select the one that bothered you the most. What is this number? _____
2. How old were you when it happened? _____
3. Approximately how old was the other person involved? _____
4. Who was the other person involved?
___ relative ___ friend or acquaintance ___ stranger
5. If the other person was a relative, how were they related to you?
(i.e., cousin, father, sister, etc.) _____
6. How many times did this behavior occur?
_____ just once _____ twice _____ 3 or 4 times _____ 5 times or more
7. Over how long a period did this behavior occur?
____ just once ____ a month or less ____ several months ____ a year or more
8. How much did the experience *bother* you at the time?

Not at all			Moderately			Extremely
1	2	3	4	5	6	7

9. How much does the experience *bother you now*?

Not at all			Moderately			Extremely
1	2	3	4	5	6	7

10. What kind of psychological pressure or physical force did the person use, if any? *Check all that apply:*

_____ They tried to talk you into it.
_____ They scared you because they were bigger and stronger.
_____ They said they would hurt you.
_____ They bribed you.
_____ They pushed, hit, or physically restrained you.
_____ You were afraid they wouldn't like or love you.
_____ They physically harmed or injured you.
_____ They threatened you with a weapon.
_____ They drugged you or got you drunk.
_____ Other (please specify): _____
_____ None of these occurred.

11. Have you talked about this in counseling? _____ Yes _____ No

12. Would you like to talk about this with your intern? _____ Yes _____ No

APPENDIX E

DEMOGRAPHICS TABLE

Table 1

Participant Demographics and Characteristics

	Survivors				Not Abused			
Variables	*n*	%	*M*	*SD*	*n*	%	*M*	*SD*
Age	73		20.06	(1.96)	95		20.30	(1.80)
Sex								
Male	27	36.5			59	60.8		
Female	47	63.5			38	39.2		
Relationship Status								
Single	57	77.0			83	87.4		
Married	2	2.7			2	2.1		
Divorced/Separated	1	1.4			1	1.0		
Live Together	12	16.2			9	9.5		
Race								
Latino	24	32.4			38	39.6		
Black	17	23.0			12	12.5		
White	13	17.6			25	26.0		
Native American	3	4.1			11	11.5		
Asian American	2	2.7			3	3.1		
Pacific Islander	2	2.7			1	1.0		
Biracial	7	9.5			1	1.0		
Other	6	8.1			5	5.2		
Sexual Orientation								
Heterosexual	55	80.9			70	85.4		
Bisexual	11	16.2			10	12.2		
Gay	2	2.9			0	0.0		
Lesbian	0	0.0			2	2.4		
Highest Level of Education								
Some Grade School	7	9.6			15	16.1		
8th Grade	7	9.6			9	9.7		
High School/GED	44	60.3			51	54.8		
Some College/ Technical Training	15	20.5			18	19.4		

Table 1

Participant Demographics and Characteristics

	Survivors				Not Abused			
Variables	*n*	%	*M*	*SD*	*n*	%	*M*	*SD*
Mother's Education Level								
Some Grade School	12	16.7			13	14.1		
8th Grade	7	9.7			15	16.3		
High School/GED	31	43.1			41	44.6		
Some College/ Technical Training	11	15.3			13	14.1		
2-Year College	2	2.8			1	1.1		
College Degree	8	11.1			5	5.4		
Master's Degree	1	1.4			3	3.3		
Doctoral Degree	0	0.0			1	1.1		
Father's Education Level								
Some Grade School	14	22.6			14	17.7		
8th Grade	11	17.7			11	13.9		
High School/GED	24	38.7			33	41.8		
Some College/ Technical Training	7	11.3			14	17.7		
2-Year College	4	6.5			1	1.3		
College Degree	1	1.6			4	5.1		
Master's Degree	1	1.6			2	2.5		
Doctoral Degree	0	0.0			0	0.0		
Parental Income								
$1 - $14,999	24	46.2			21	32.8		
$15,000 - $29,999	13	25.0			16	25.0		
$30,000 – $44,999	9	17.3			15	23.4		
$45,000 - $59,999	2	3.8			8	12.5		
$60,000 – $74,000	3	5.8			4	6.3		
$75,000 or more	1	1.9			0	0.0		

BIOGRAPHICAL SKETCH

Sarah Katheryn Staley was born in Auburn, California, on July 23, 1981. She received her elementary education from the Placer Hills Union School District in Meadow Vista and Weimar, California. She completed her secondary education at Apache Junction High School in Apache Junction, Arizona. Sarah began her higher education at Arizona State University (ASU) where, in May 2003, she graduated from The Barratt Honors College and earned a bachelor's degree in interdisciplinary studies focusing in biology and sociology. Her undergraduate thesis, which received the Thesis of Distinction award, focused on sexual health education and awareness. While at ASU, Sarah was involved with student government and served a year as an elected Student Body Vice-President. In May 2006, Sarah completed her Masters of Public Health specializing in Health Promotion at The George Washington University in Washington, DC. Her master's thesis was on college violence prevention through the use of mediation services. Sarah began her doctoral studies in Counseling Psychology at Arizona State University in fall 2006. While at ASU, Sarah received a Teaching Excellence-Graduate Students award, was granted a Graduate Student Fellowship by the Division of Counseling and Human Development of the American Educational Research Association, and was recognized for her research by the Student Affiliate of Seventeen of the American Psychological Association. She completed her predoctoral psychology internship at the University of California, Berkeley. Sarah looks forward to pursuing her professional interests in counseling, teaching, research, and consulting. She would like to continue working with at-risk youth and survivors of trauma, specifically childhood sexual abuse.