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Exploring Gender and Racial/Ethnic Differences in the Effects of Child Sexual Abuse

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ABSTRACT

Child sexual abuse (CSA) has been linked to a number of adverse effects including hypersexuality (HYP), substance use (SUB), suicidality (SUI), and depression (DEP). Despite a plethora of research on CSA, little is known about how it affects adolescents and the cultural factors that influence their coping styles. This study was founded on social-cultural coping theory and the model of traumagenic dynamics of sexual abuse, suggesting that CSA consequences lead to maladaptive coping mechanisms influenced by sociocultural factors. Using archival data, loglinear analysis was conducted to examine gender differences within racial/ethnic groups in HYP, SUI, DEP, and SUB among adolescent survivors of CSA in a National sample of 13,583 male and female high school students. The purpose of the study was to identify differences in the effects of CSA as manifested by variations of maladaptive coping across racial/ethnic groups and gender. Boys were significantly more likely to use substances, while girls were more likely to experience depressive symptoms and suicidality. Notably, this study did not reveal any significant racial/ethnic differences in adolescent coping. These findings can inform treatment planning and interventions for adolescents who may present with DEP, SUI, SUB, or risky sexual behaviors, but may have underlying trauma from CSA. This study contributes to the knowledge base about the processes that take place within adolescent CSA survivors, shedding light on cultural nuances among adolescent coping and informing culturally competent practice.

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Gender and racial/ethnic differences in the effects of child sexual abuse

Child sexual abuse (CSA) is defined as the use of a child (18 years and under) for the purposes of sexual pleasure with or without physical contact from another individual whether known, unknown, older, or the same age (Olafson, 2011). It is further defined as a sexual crime committed on a minor by another individual including a friend, peer, another child, adult, relative, or stranger (Finkelhor, 2009). There are several long-term and short-

term effects associated with sexual abuse. The effects of abuse include an increased risk for substance abuse and depression, anxiety, interpersonal problems, aggression, anger, and difficulty trusting others due to negative attachments (Wurtele, 2009).

CSA is a worldwide phenomenon that crosses all cultural and socioeconomic status boundaries and continues to impact children on a daily basis. Although current prevalence estimates of CSA are based on official data sources (e.g., governmental agencies, child welfare, etc.), these estimates only account for substantiated or reported cases (Douglas & Finkelhor, 2011). In fact, according to these estimates, CSA affects 1.2 out of every 1000 children (Douglas & Finkelhor, 2011). Although researchers have explored the long- and short-term effects of CSA, the data that explore the differential effects of CSA across gender and ethnicity are lacking, and little research on CSA has focused on male adolescents. Moreover, how individuals cope varies across cultural groups and provides insight as to the risk of developing long-term psychiatric problems in adolescents who have experienced CSA (Shapiro, Kaplow, Amaya-Jackson, & Dodge, 2012). Avoidant coping strategies such as substance abuse, suicidal ideation, depression, and hypersexuality have been identified as some of the adverse effects of CSA. However, it remains unknown how these effects are manifested during adolescence and how they differ from one racial/ethnic group to another and between boys and girls. In the psychological community, successful treatment is guided by accurate assessment of presenting symptoms and case conceptualization. As such, shedding light on these differences from a culturally competent perspective poses several implications for the treatment of adolescents who have experienced CSA. Thus, shedding light on the effects of CSA and the cultural considerations associated with it may provide insight to treatment interventions, symptom management, and prevention of the development of long-term effects of CSA (i.e., psychiatric problems) that often remain pervasive well into adulthood.

Child sexual abuse

Prevalence and gender

Rates for CSA indicate a higher prevalence in girls than in boys with most perpetrators being known to the survivor and most often male (Olafson, 2011). Girls are two to three times more likely to be sexually abused compared to boys (Barth, Bermetz, Heim, Trelle, & Tonia, 2013; Finkelhor, 2009). These estimates, however, are confounded by underreporting, unsubstantiated cases, and social stigma about the abuse of boys. Additionally, these differences may be due to methodological issues such that the focus of most CSA studies has been on female survivors. As such, research questions regarding CSA have not adequately addressed CSA experiences of boys

(Barth et al., 2013). Nevertheless, prevalence rates continue to place girls as more at risk of CSA. The risk of CSA for girls continues to increase with age, whereas for boys, the highest risk is during puberty and then diminishes (Finkelhor, 2009). The most current rates indicate that 6% of all children are sexually abused every year (Finkelhor, 2009), but it is likely that the incidence of CSA may be higher.

Racial and ethnic differences

According to the U.S. Department of Health and Human Services (2013), in 2012, the child abuse rates were comprised of 21% African American, 1.2% American Indian/Alaskan Native, 0.8% Asian, 21.8% Hispanic, 4.7% Pacific Islander, 8.2% White, and 10.8% multiracial children. However, similar to other findings on CSA, most racial ethnic differences examined have been based on adult surveys. Notably, results regarding racial/ethnic differences from these surveys have been equivocal (Berliner, 2011; Fontes & Plummer, 2010; Jones et al., 2013; Lee et al., 2012; Olafson, 2011; Thompson, McGee, & Mays, 2012). As such, these findings may not be commensurate with actual rates by racial/ethnic groups given underreporting due to the stigma associated with CSA within cultures.

Adolescents

Of the few studies on adolescents, most have focused on female survivors. What is known regarding adolescent CSA experiences is that adolescents are at an increased risk for long-term psychiatric problems (Shapiro et al., 2012) including revictimization, substance abuse, depression, and hypersexuality (Olafson, 2011). Additionally, coping plays a significant role in determining the severity and duration of these negative consequences of CSA (Shapiro et al., 2012).

Consequences of CSA

Emotional dysregulation is one of the negative effects resulting from CSA that negatively impacts children, placing them at higher risk for psychological disorders (Messman-Moore, Walsh, & DiLillo, 2010). CSA survivors experiencing emotional dysregulation will often display symptoms well into adulthood, and consequently engage in maladaptive coping such as self-harming behaviors, substance abuse, and risky sexual behavior (Messman-Moore et al., 2010).

Externalizing symptoms

CSA has been linked to risky behavior that has been examined in retrospect in adult survivors (Jones et al., 2013). Although the consequences of CSA can vary from one individual to another, symptoms may be lifelong, impacting survivors psychologically, behaviorally, and physically (Olafson,

2011). Notably, CSA consequences are on a spectrum with some survivors being asymptomatic, while others experience impairment in overall functioning. These symptoms vary due to multiple factors (e.g., duration and nature of abuse, relationship to the perpetrator, support network, and gender) that will influence symptom severity and duration (Olafson, 2011).

Substance use

Children who have been sexually abused are more likely to use alcohol in adulthood than children who have experienced other forms of childhood maltreatment even without a family history of alcohol abuse (Olafson, 2011). Schraufnagel, Davis, George, and Norris (2010) found that the severity of CSA was associated with early onset drinking and suggested that early age drinking was utilized as a coping mechanism. Thus, in adolescents, alcohol abuse as a coping mechanism may present with long-term CSA consequences and negative coping mechanisms.

In another study (Behnken, Le, Temple, & Berenson, 2010), researchers found that binge drinking mediated the relationship between CSA and suicidality. Moreover, they found that CSA was associated with binge drinking and that binge drinking may increase the risk for suicidality in sexually abused adolescent girls, but not for all racial/ethnic groups (Behnken et al., 2010), suggesting that perhaps, rather than binge drinking contributing toward increased suicidality, binge drinking may be an additional coping mechanism used by CSA survivors for avoidance.

Hypersexuality

Hypersexuality is defined as pathological sexual behavior that is both repeated and high risk (Adelson et al., 2012). It may be a result of traumatic sexualization which is the distorted sexuality of a CSA survivor resulting from the sexual abuse (Collin-Vézina, Daigneault, & Hébert, 2013). It may further result in confusion regarding sexual behavior which may lead to a distorted perception of sexual relationships. Hypersexual behavior is posited to be a self-soothing behavior or coping mechanism in CSA survivors that contributes toward emotional regulation (Messman-Moore et al., 2010). CSA is linked to increased sexual behaviors during childhood, having a higher number of sexual partners, engaging in intercourse both at a younger age and more frequently in adolescence, and consequently, a higher risk for adolescent rape (Adelson et al., 2012; Fargo, 2009; Messman-Moore et al., 2010; Schraufnagel et al., 2010). Notably, the risk for revictimization is higher in adolescence and is mediated by other factors such as alcohol use before sexual activity, engaging in risky sexual behavior, child physical abuse history, and lack of familial support (Fargo, 2009).

Internalizing symptoms

There is a significant relationship between childhood trauma and depressive disorders (Olafson, 2011). More specifically, CSA has been associated with major depressive disorder and posttraumatic stress disorder (PTSD) (Bedi et al., 2011). The severity of the abuse is also a predictor of long-lasting symptoms leading to increased risk of impairment in functioning due to PTSD, dissociative disorders, substance abuse, anxiety, and conduct problems (Olafson, 2011).

Depression and suicidality

Suicide is among the top three causes of death in individuals aged 15–24 years and is associated with CSA (Bedi et al., 2011; Rhodes et al., 2011). The association between CSA and suicidal ideation and behaviors is significantly stronger in male adult survivors compared to female survivors (Rhodes et al., 2011). Bedi et al. (2011) found that women with CSA histories attempted suicide 5 years earlier than men, yet the risks were consistent in both genders. CSA was found to be directly associated with suicidal behavior in adults who were not experiencing depressive or PTSD symptoms (Bedi et al., 2011) suggesting that CSA alone is a predictor of suicidality.

Overall, CSA is associated with increased risk for suicidal ideation (Bedi et al., 2011; Rhodes et al., 2011), substance abuse, depression (Olafson, 2011), and risky sexual behavior (Homma, Wang, Saewyc, & Kishor, 2012). However, it remains to be studied what cultural factors (i.e., race, ethnicity, and gender) influence coping mechanisms that translate into the negative consequences of CSA.

Theoretical foundations and framework

Model of traumagenic dynamics in CSA

Finkelhor and Browne (1985) proposed a theory of CSA based on traumagenic dynamics of CSA. They posited that four factors contribute to trauma: (a) traumatic sexualization, (b) betrayal, (c) powerlessness, and (d) stigmatization. Survivors who experience the effects of stigmatization may resort to maladaptive coping strategies such as drug and/or alcohol abuse, self-harming behaviors, low self-esteem, and risky sexual behaviors (Finkelhor & Browne, 1985). Betrayal and powerlessness may result in feelings of loss, grief, loss of control, suicidal behavior, and depression especially when the abuse is perpetrated by a close loved one the child trusted (Finkelhor & Browne, 1985). This model provides insight as to how CSA impacts children and how CSA may be an underlying factor to externalizing and internalizing behaviors. These behaviors, manifested as symptoms or behavioral problems, serve as a coping mechanism for survivors. For instance, individuals who experience trauma also experience symptoms of avoidance. Adolescents may

resort to drug use, suicide, withdrawal, and risky sexual relationships in order to avoid dealing with the trauma.

Sociocultural coping theory

Although Finkelhor and Browne's theory provides a framework for assessing trauma in CSA survivors, it does not address racial/ethnic and gender related factors that may influence coping. Aldwin's (2007) sociocultural theory of coping proposes that the culture of an individual influences how stressors are perceived and how one interprets, copes, and seeks help or support. Thus, culture also dictates how one implements a given coping mechanism (Aldwin, 2007). Furthermore, culture plays a role as to what types of stressors are experienced and how supportive one's family is. This will likely impact coping and perceived support (Aldwin, 2007). Fontes and Plummer (2010) explained that CSA disclosures are dependent on cultural norms and gender as well as other factors. The social and cultural factors that impact coping include gender, age, family, context, race, and ethnicity. One of the greatest social-cultural distinctions in coping is gender despite the lack of consensus in the literature regarding whether gender differences exist (Aldwin, 2007). How boys cope compared to girls may be influenced by social and gender roles (Aldwin, 2007) and the social context. This is particularly true for adolescents who may turn to their peers for coping which may result in maladaptive coping styles (i.e., substance use) through peer pressure (Aldwin, 2007). Therefore, emotion-focused and problem-focused coping will take on various forms from one culture and individual to another (Aldwin, 2007).

Method

This study examined (a) whether there are differences in substance use, hypersexual behavior, depressive symptomatology, and suicidal ideation between boys and girls who have been sexually abused and (b) whether there are differences in substance abuse, hypersexual behavior, depressive symptomatology, and suicidal ideation between African American, White, and Hispanic adolescent CSA survivors. Archival data were utilized from a national database, the 2013 Youth Risk Behavior Survey (YRBS), conducted by the Centers for Disease Control (CDC). Substance use was defined as endorsing having used alcohol or marijuana three or more times in the last 30 days, or having used cocaine, methamphetamines, heroin, or ecstasy three or more times in one's lifetime. Suicidality was answering "yes" to having seriously considered attempting suicide in the past 12 months and having a plan for suicide in the past 12 months. Depressive symptomatology was a "yes" response to feeling sad or hopeless every day for 2 weeks or more in a row in the past 12 months. Hypersexuality was sexual intercourse with four or more people during the lifetime and/or two or more people during the past 3 months.

Sample

The 2013 YRBS consisted of a sampling frame of students in grades 9–12 enrolled in both public and private schools in the United States (CDC, 2013b). The sample consisted of 13,583 male and female students. Of these, 6,950 identified as male and 6,621 identified as female. Notably, of the overall sample, 1,026 adolescents reported having been forced to engage in sexual intercourse (i.e., CSA); these were utilized in this study. This was a representative sample of high school students in the United States by race, ethnicity, sex, and grades (CDC, 2013a). The YRBS uses a three-cluster sampling design to obtain a nationally representative sample (Centers for Disease Control and Prevention, 2013a). Weights based on sex, race, and ethnicity were implemented to adjust for non-responding and the oversampling of Blacks and Hispanics (Centers for Disease Control and Prevention, 2013a). Additionally, individuals who refused to participate were not replaced to maintain integrity and avoid unmeasurable bias (Centers for Disease Control and Prevention, 2013a). Table 1 describes the sampling process used by the 2013 YRBS.

Results

Hierarchical loglinear analysis was conducted to determine racial/ethnic and gender differences in the hypersexual behavior of adolescents who experienced CSA. Results indicate that the three-way interaction term Race*Gender*Hypersexuality was not statistically significant ($p = .30$). Therefore, it can be concluded that there were no statistically significant gender differences within racial/ethnic groups in hypersexual behavior among the adolescent CSA survivors in the sample.

Hierarchical loglinear analysis was conducted to identify racial/ethnic and gender differences in substance use among adolescents who experienced CSA. Substance abuse included the use of alcohol, marijuana, cocaine (i.e., including powder, crack, or freebase), methamphetamines (i.e., also called

Table 1. Description of the 2013 YRBS sampling process.

Cluster	Sampling frame	Process
1	Primary sampling units (PSU)	PSU's were comprised of counties, large counties, subareas of counties, and groups of smaller adjacent counties. These were categorized into 16 strata according to their metropolitan statistical area (MSA) and percentages of Blacks and Hispanic students.
2	Clusters	Drawn from the PSUs, 193 schools were sampled with proportional probability of overall student enrollment size.
2	Classes	Random samples were drawn from classes from each of the grades 9–12 from a required classes or period such as English, Social Studies, homeroom, or second period.

Note: Weighting ensured that the sample was nationally representative of students, grades 9–12, in the United States.

speed, crystal, crank, or ice), heroin (i.e., also called smack, junk, or China White), and ecstasy (also called MDMA). The three-way interaction between Race*Gender*Substance was not statistically ($p = .292$) significant in the loglinear analysis. Therefore, it can be concluded that there were no gender differences within racial/ethnic groups in substance use among the sample of adolescent CSA survivors. However, there was a significant two-way interaction between gender and substance use ($p = .001$) suggestive that there are gender differences in substance use. Specifically, boys who experienced CSA (62.5%) were more likely to report substance use than girls who experienced CSA (42.3%).

Hierarchical loglinear analysis was conducted to analyze whether there are gender differences within racial/ethnic groups in suicidal ideation among adolescent CSA survivors. Using SPSS, a general loglinear analysis was conducted using a GENLOG module (Garson, 2012). Contingency tables were developed for all hypotheses using the factors gender (GEN), race/ethnicity (ETH), depression (DEP), suicidality (SUI), hypersexuality (HYP), and substance use (SUB). For the purposes of this analysis, each variable, or factor defined the rows and columns for the following models:

- (1) GEN x ETH x DEP
- (2) GEN x ETH x SUI
- (3) GEN x ETH x HYP
- (4) GEN x ETH x SUB

Each analysis produced three main effects, three 2-way interactions, and one 3-way interaction. Based on the results of the loglinear model, Race*Gender*suicidal ideation does not have a statistically significant effect. Therefore, it can be concluded that there were no gender differences within racial/ethnic (White/non-White) groups in suicidal ideation among the sample of adolescent CSA survivors. Of note, there was a significant two-way interaction between gender and suicidal ideation ($p = .001$) suggestive that there are gender differences in suicidal ideation. Girls who reported CSA (48.4%), were more likely to experience suicidal ideation compared to boys with reported CSA (36.5%).

Hierarchical loglinear analysis was conducted to determine whether or not there are gender differences within racial/ethnic groups in depressive symptomatology among adolescent CSA survivors. Based on the results of the analysis, the interaction term Race*Gender*Depression does not have a significant effect. Therefore, there were no significant gender differences within racial/ethnic groups in depressive symptomatology among the sample of adolescent CSA survivors. Notably, there was a significant two-way interaction between gender and depressive symptomatology ($p = .001$) suggestive that there were significant gender differences in depressive symptomatology.

Girls who reported CSA reported experiencing depressive symptomatology at higher rates (66.9%) than boys (46%).

Discussion

This analysis did not find any significant three-way interactions among the variables race/ethnicity, gender, and hypersexuality; race/ethnicity, gender, and substance use; race/ethnicity, gender, and suicidality; or race/ethnicity, gender, and depressive symptomatology. Nonetheless, there were three significant two-way interactions which indicated that gender played a significant role in substance use, suicidal ideation, and depressive symptomatology in adolescents who have been sexually abused. Of the overall sample, 1,026 adolescents reported having been forced to engage in sexual intercourse (i.e., CSA). Of those that reported CSA, 70% ($n = 717$) were female, and 30% ($n = 309$) were male, consistent with research indicating girls are two to three times more likely to experience CSA than boys (Barth et al., 2013; Finkelhor, 2009). Nevertheless, this study contributed to the knowledge base of the underlying processes that occur in male adolescents who have experienced CSA given that studies on boys have been limited to retrospective surveys of adult men with CSA histories (Schraufnagel et al., 2010).

Gender and racial/ethnic background made significant contributions to overall fit of the models such that these variables together play a role in the interactions between the variables substance use, depressive symptomatology, suicidal ideation, and hypersexuality in all four models. However, this study did not reveal any significant interactions in race/ethnicity with regard to coping mechanism or effects of CSA suggesting that these main effects (i.e., the contribution to the model) may need to be examined further in order to determine more specifically what role race/ethnicity play among these variables. Researchers have suggested racial/ethnic differences in the prevalence of CSA (Berliner, 2011 as cited in Olafson, 2011; Lee et al., 2012; Thompson et al., 2012). However, current research does not indicate that racial/ethnic differences influence externalizing behaviors in CSA survivors (Jones et al., 2013) which was consistent with the findings of this study. Researchers have indicated that there are various cultural factors that contribute to disclosure of CSA including level of acculturation, type of abuse (i.e., intercourse, fondling, exposure), the perpetrator–victim relationship, and racial/ethnic background (Fontes & Plummer, 2010). This may suggest that, again, race/ethnicity play more of a role. As such, it is likely that this study did not capture these factors given the use of archival data. Moreover, the race/ethnicity variable was dichotomized into two groups (i.e., White/non-White) which may have contributed to the lack of significant findings for racial/ethnic differences in any of the research hypotheses. That is, this study did not examine differences between individual groups (i.e., Blacks, Whites,

and Hispanics). As such, dichotomizing these racial/ethnic groups may have led to the loss of main effects and power, as well as the loss of differences among these groups. Given that this study revealed that race/ethnicity made a statistically significant contribution to the overall fit of the model, it is likely that recoding this variable may have been a flaw in this study. Overall, this study did not identify any race/ethnic differences in how adolescents cope with CSA. Nonetheless, the findings did suggest that race and ethnicity made a statistically significant contribution to the models.

Similarly, although gender did play a role in the interactions in all the models, there were no gender differences within race/ethnicity. Nevertheless, there were significant interactions between gender and substance use, gender and suicidal ideation, and gender and depressive symptomatology. Specifically, boys who reported CSA (62.5%) were more likely to engage in substance use than girls (42.3%). Girls who reported CSA were more likely to report depressive symptomatology (66.9%) and suicidal ideation (48.4%) than boys (46% and 36.5%, respectively). This indicates that gender plays an influencing role on how an adolescent may cope with sexual abuse as it pertains to substance use, suicidal ideation, and depressive symptomatology.

Regarding substance use, these findings were consistent with the literature indicating that children who have been sexually abused are more likely to use alcohol than children experiencing other forms of childhood maltreatment (Olafson, 2011). Furthermore, these findings were consistent with the literature suggesting that there are gender differences in the use of substances for CSA survivors (Shin, Edwards, & Heeren, 2009). Notably, much of the research on substance abuse in individuals with CSA histories is limited to girls due to small male samples (Shin et al., 2009; Thompson et al., 2012). This study contributed to the literature by shedding light on the coping mechanisms of boys who have experienced CSA. Specifically, the findings indicate that male adolescents who have experienced CSA are more likely to utilize substances as a means of coping than their female counterparts. Adolescence is a critical time in development. As such, these findings have several implications for male survivors, treatment, and long-term consequences. From a sociocultural coping perspective, context (e.g., peer groups), gender, and age are essential factors in substance use as well as treatment approach. Peer influences and masculinity in adolescence are intertwined and may contribute to risk taking behaviors such as substance use. For example, refusing to participate in the use of substances in a peer group may negatively impact masculinity. Similarly, as mentioned before, disclosing CSA also has negative effects on masculinity. Consequently, boys may be more likely to seek out substances as a means coping with their CSA experience(s), and unfortunately, this may lead to long-term substance use disorders among adolescents who have experienced CSA.

With regard to depressive symptomatology and suicidal ideation, the findings from this study were consistent with the literature which indicates that CSA is directly associated with suicidal behavior in adult survivors as well as a predictor of suicidality and depression in adolescents (Bedi et al., 2011). Although previous research indicates that CSA is associated with depression and suicidal ideation, gender differences remained unclear. This study added to the literature by identifying gender differences in coping, suggesting that female CSA survivors are more likely to experience depressive symptomatology and suicidal ideation compared to male adolescents. Together, these findings suggest that girls experience higher rates of depression than boys who have experienced CSA. Depression and suicidality, through the lens of coping, are forms of emotional avoidance. This avoidance often leads to isolation and withdrawal which are common behaviors among individuals experiencing depressive symptomatology, alongside recurrent thoughts of death (i.e., suicidal ideation). This presents with significant implications for treatment and prevention, given that suicide is the third leading cause of death among adolescents aged 10–14 (CDC, 2015).

The findings did not reveal any significant interactions between gender, race/ethnicity, and hypersexual behavior suggesting that there were no gender or racial ethnic differences in the rates at which adolescents with CSA engage in hypersexual behavior. Nevertheless, individuals who reported forced sexual intercourse were engaging in risky sexual behaviors (i.e., sexual intercourse with multiple partners). In this study, 48.5% of girls with CSA and 53.7% of boys reported hypersexual behavior. This was consistent with the research indicating that CSA survivors are more likely to engage in risky sexual behaviors as a means of coping (Adelson et al., 2012; Homma et al., 2012; Messman-Moore et al., 2010). These results suggest that although there were no gender or racial/ethnic differences, adolescents who reported experiencing CSA also reported engaging in high risk sexual behaviors (i.e., having sexual intercourse with multiple partners). Moreover, consistent with the Model of Traumagenic Dynamics in Sexual Abuse, individuals who are sexualized through a CSA may become promiscuous and hypersexualized as a result (Finkelhor & Browne, 1985).

The findings of this study are consistent with the Sociocultural Coping Theory suggesting that gender is one of the greatest social-cultural distinctions in coping (Aldwin, 2007). As mentioned earlier, this study revealed gender differences in substance abuse, depressive symptomatology, and suicidal ideation. Gender, context (e.g., peer groups, school, and environment), as well as age are sociocultural factors that influence coping. The theory posits that social context impacts coping for adolescents given the importance of peers, which may result in maladaptive coping styles (Aldwin, 2007). For example, issues of masculinity, peer influence, and being part of an in-group may influence coping styles, risk taking, and decision making in male

adolescents. Additionally, consistent with the Model of Traumagenic Dynamics in Sexual Abuse (Finkelhor & Browne, 1985), survivors may resort to maladaptive coping strategies resulting in substance use, suicidal behavior, and depression (Finkelhor & Browne, 1985). Finkelhor and Browne (1985) identified substance use, depressive symptoms, as well as suicidality, as avoidant coping and suppression of emotions. Stigmatization, betrayal, and powerlessness experienced as a consequence of CSA result in maladaptive coping strategies manifested as symptoms or behavioral problems. Avoidance of dealing with the trauma may come in the form of depressive symptoms including hopelessness and isolation. As mentioned in Chapter 2, hopelessness increases the risk of suicidality, an extreme form of avoidance of dealing with emotional pain.

Limitations

There were several limitations due to the design of this study (i.e., *ex post facto* design). First, control was limited due to the use of archival data. As such, this study did not encompass all types of CSA (e.g., molestation, exposure, etc.) given that responses were based on the YRBS questionnaire (i.e., Have you ever been forced to engage in sexual intercourse?). Additionally, sampling bias was a limitation. Although the sample included high school students within the 50 states in United States, these findings cannot be generalized to students who are homeschooled, have dropped out, or live in a different geographic area. Individuals who may have dropped out of school are more likely to engage in health risk behaviors (CDC, 2013a). As such, including this population may impact findings given that there may be a higher prevalence of reports of CSA and maladaptive coping. Additionally, including other geographic areas outside the United States may have highlighted some more salient racial/ethnic differences given issues of acculturation.

Self-report is another limitation to this study as it is uncertain the extent to which adolescents were honest in their answers. Moreover, recall bias and social desirability bias may influence reporting. First, in traumatic experiences such as CSA, there are factors such as dissociation, which may negatively impact the ability to accurately recall an event. Moreover, individuals may have difficulty retrieving a memory or remember it inaccurately. Socially desirable answers may influence responses given the nature of the topic (i.e., CSA). Albeit that the data were collected anonymously, underreporting may have occurred as individuals tend to respond in a socially desirable manner. As such, the extent of underreporting cannot be determined (CDC, 2013a). Other factors such as culture and gender may influence responses as CSA disclosures are influenced by these factors (Fontes & Plummer, 2010). In fact, there are a number of issues influencing disclosure of abuse including the

relationship between the perpetrator, whether or not the survivor is using substances, as well as the survivor's sex and age (Fontes & Plummer, 2010). For instance, researchers have found a relationship between level of acculturation and disclosure (Fontes & Plummer, 2010). Others (Fontes & Plummer, 2010) have indicated that Hispanic girls are more likely to live with their perpetrator or be abused by a parent compared to their White and African American counterparts. Furthermore, Hispanic girls are more likely to wait longer to disclose compared to Whites and African Americans (Fontes & Plummer, 2010). Boys may be less likely to report CSA because of social stigmas regarding masculinity. For example, a male abused by another male may avoid disclosing in order to avoid being perceived as gay (Barth et al., 2013). Conversely, a male abused by a female may not disclose in an effort to avoid negatively impacting his masculinity by admitting to having been victimized (i.e., the sexual encounter was unwanted, and he was not in control).

Finally, a loglinear analysis only allows for examining interactions among variables such that, it is a confirmatory analysis. As such, the analyses did not examine further the extent of the significant contribution that race/ethnicity made to the overall fit of the model. Additionally, as mentioned earlier, it is likely that the dichotomization of the variables negatively impacted the results, such that, there were no significant racial/ethnic differences in any of the hypotheses.

Recommendations for future research

The findings from this study suggest that gender influences the types of coping mechanism that adolescents employ. Currently, the literature on gender differences in the effects of CSA is lacking. Rather, the research indicates that the CSA is associated with substance use (Schraufnagel et al., 2010), but does not allude to any gender differences in coping. This study added to the knowledge base by identifying these gender differences in an adolescent sample which included boys. Although research has examined racial/ethnic differences in substance use in female survivors who have experienced CSA, these findings are limited to female survivors only (Shin et al., 2009; Thompson et al., 2012). This study provided some insight as to the coping mechanisms of boys who have experienced CSA. Future researchers may wish to further explore these findings which indicate that boys are more likely to use substance than girls who have experienced CSA. Particularly, future research may expand on these findings and examine further the experiences of boys who have experienced CSA which may potentially identify underlying factors of substance abuse (e.g., depression). Additionally, as discussed earlier, this study did not encompass all possible CSA experiences. Future research should focus on including various

experiences of CSA in order to explore more in-depth the effects of CSA on adolescents and their coping mechanisms. Qualitative research may also provide more insight as to the cultural factors that influence coping as well as the lived experiences of adolescents who have experienced CSA. Research indicates that individuals who have experienced CSA are more likely to experience depression and suicidality (Bedi et al., 2011). As such, qualitative research (i.e., interviews) may provide insight as to why and how girls experience depression and suicidal ideation at higher rates than boys. That is, are girls more likely to report depressive symptoms and suicidal thoughts because socially it is more acceptable for girls to verbalize their emotions? Conversely, qualitative interviews may provide insight as to what the underlying factors of substance use are in boys. For example, boys who report CSA may be using substances in an effort to self-medicate underlying mental health problems which may include depressive symptomatology.

Implications

This study sheds light on the gender differences in coping mechanisms utilized in adolescents who have experienced CSA. Specifically, it sheds light as to what these differences may look like in a clinical setting across genders and informs treatment. Due to the high risk for CSA in adolescence (Finkelhor, Shattuck, Turner, & Hamby, 2014), it is essential to identify how different groups of adolescents cope with and experience CSA. Therefore, these findings may improve treatment and prevention programs by increasing the understanding of sociocultural differences in coping. Cultural competence extends outside of race and culture and is an ongoing process that involves the consideration of the sociocultural context from the treatment provider (Huey, Tilley, Jones, & Smith, 2014). As such, more tailored and individualized approaches to treatment can be implemented through increasing cultural competence.

Moreover, avoidant coping, including substance use, depressive symptomatology, and suicidal ideation negatively impact mental health (Shapiro et al., 2012). As such, findings will further inform treatment interventions for youth who present with depressive symptoms, substance use, suicidal ideation, or hypersexual behaviors that may have underlying trauma. Identifying patterns of coping may promote the implementation of effective interventions in CSA survivors. For instance, the findings inform treatment by identifying the gender differences in coping and ultimately clinical presentation (i.e., depression, substance use, suicidal ideation). In practice, knowledge of these gender differences in coping within the context of CSA may inform treatment and prevention for a child who has experienced CSA. For example, when a child or adolescent has been identified as having been victimized, reported symptoms can be viewed through the lens of trauma

(i.e., CSA). Observed or reported maladaptive coping mechanisms can be targeted in treatment and viewed as a coping strategy, rather than a separate diagnosis. Once these coping mechanisms are identified, supportive services and resources, teaching effective coping skills, and communication skills may be implemented in treatment planning in an effort to prevent the development of or maintenance of maladaptive coping. Simultaneously, the clinician is aware that CSA is an underlying factor, and treatment can be approached within this context while providing psychoeducation to caregivers and the child/adolescent.

Prevention

The consequences of CSA go well into adulthood and may develop into long-term psychological problems (Shapiro et al., 2012). Coping is an indicator of the development of long-term psychiatric symptomatology (Shapiro et al., 2012). As such, this study demonstrates that there are factors such as gender which are related to coping style in adolescents who have experienced CSA. Thus, identifying children via observed coping may provide a starting point for prevention. Findings from this study may help guide clinician exploration of underlying causes for externalizing and internalizing symptoms and behaviors in order to inform treatment, prevent the development of long-term consequences, and potentially identify individuals who have not disclosed CSA when they present with these symptoms.

Social change

This study contributes to positive social change globally by eliciting more research in the area of gender and racial/ethnic differences in coping. It contributes to the knowledge base about physically and behaviorally expressed effects of CSA in adolescents by providing information about the effect of sociocultural influences (i.e., gender and adolescence) on coping within the context of CSA. This study further informs culturally competent practice by informing clinicians on considerations in treatment. As mentioned earlier, cultural competence entails the modification of any treatment approach in order to tailor treatment to sociocultural factors which influence the presenting problem (Huey et al., 2014). Furthermore, it assists in the prevention of the development and maintenance of adverse, long-term, psychiatric problems and persistent symptomatology resulting from CSA through the identification of an adolescent's coping mechanisms (Shapiro et al., 2012).

Currently, in the literature, there are no studies which call for such a shift in the perception of behavioral or emotional consequences of CSA in adolescents.

Ultimately, this study calls for a shift on the perception of survivors as problem children or problem behaviors rather than an individual attempting to cope with a trauma such as CSA. Specifically, adolescents who are identified as having internalizing symptoms and/or externalizing symptoms or behaviors may be labeled as problem children when in fact they may be coping with their experience with CSA. Children who are stigmatized due to both CSA and their maladaptive coping strategies (e.g., those identified as having behavior problems or withdrawn) may in turn develop an increased sense of self-worth if they are educated as to the where their current emotional or behavioral problems stem from (i.e., CSA and trauma). Furthermore, family members, caregivers, and providers may shift their perceptions of these youth through psychoeducation and increased understanding of the effects of CSA on behavioral, emotional, and psychological functioning, thereby impacting societal perceptions of CSA survivors.

Disclosure statement

No potential conflict of interest was reported by the authors.

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References

- Adelson, S., Bell, R., Graff, A., Goldenberg, D., Haase, E., Downey, J. I., & Friedman, R. C. (2012). Toward a definition of 'hypersexuality' in children and adolescents. *Psychodynamic Psychiatry, 40*(3), 481–503. doi:10.1521/pdps.2012.40.3.481
- Aldwin, C. M. (2007). *Stress, Coping, and Development: An Integrative Perspective* (2nd ed).
- Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: A systematic review and meta-analysis. *International Journal of Public Health, 58*(3), 469–483. doi:10.1007/s00038-012-0426-1
- Bedi, S., Nelson, E. C., Lynskey, M. T., McCutcheon, V. V., Heath, A. C., Madden, P. F., & Martin, N. G. (2011). Risk for suicidal thoughts and behavior after childhood sexual abuse in women and men. *Suicide & Life-Threatening Behavior, 41*(4), 406–415. doi:10.1111/j.1943-278X.2011.00040.x
- Behnken, M. P., Le, Y. L., Temple, J. R., & Berenson, A. B. (2010). Forced sexual intercourse, suicidality, and binge drinking among adolescent girls. *Addictive Behaviors, 35*(5), 507–509. doi:10.1016/j.addbeh.2009.12.008
- Berliner, L. (2011). Child sexual abuse: Definitions, prevalence, and consequences. In E. B. Myers (Ed.), *The APSCA handbook on child maltreatment* (Vol. 3, pp. 215–232). Los Angeles, CA: Sage.

- Centers for Disease Control and Prevention. (2013a). Methodology of the Youth Risk Behavior Surveillance System-2013. Retrieved from: <http://www.cdc.gov/mmwr/pdf/rr/rr6201.pdf>
- Centers for Disease Control and Prevention. (2013b). Youth Risk Behavior Surveillance System - United States, 2013. Retrieved from: <http://www.cdc.gov/mmwr/pdf/ss/ss6304.pdf>
- Centers for Disease Control and Prevention (2015). Suicide facts at a glance. Retrieved from <http://www.cdc.gov/violenceprevention/pdf/suicide-datasheet-a.pdf>
- Collin-Vézina, D., Daigneault, I., & Hébert, M. (2013). Lessons learned from child sexual abuse research: Prevalence, outcomes, and preventive strategies. *Child and Adolescent Psychiatry and Mental Health*, 7(1), 22–30. doi:10.1186/1753-2000-7-22
- Douglas, E., & Finkelhor, D. (2011) Childhood sexual abuse fact sheet, Crimes against Children Research Center. Retrieved from: <http://www.unh.edu/ccrc/factsheet/pdf/CSA-FS20.pdf>
- Fargo, J. D. (2009). Pathways to adult sexual revictimization: direct and indirect behavioral risk factors across the lifespan. *Journal Of Interpersonal Violence*, 24(11), 1771-1791.
- Finkelhor, D. (2009). The prevention of childhood sexual abuse. *Future of Children*, 19(2), 169-194. Retrieved from EBSCOhost.
- Finkelhor, D., & Browne, A. (1985). The traumatic impact of child sexual abuse: A conceptualization. *American Journal of Orthopsychiatry*, 55(4), 530–541. doi:10.1111/j.1939-0025.1985.tb02703.x
- Finkelhor, D., Shattuck, A., Turner, H. A., & Hamby, S. L. (2014). The lifetime prevalence of child sexual abuse and sexual assault assessed in late adolescence. *Journal of Adolescent Health*, 55(3), 329–333. doi:10.1016/j.jadohealth.2013.12.026
- Fontes, L. A., & Plummer, C. (2010). Cultural issues in disclosures of child sexual abuse. *Journal of Child Sexual Abuse*, 19(5), 491–518. doi:10.1080/10538712.2010.512520
- Garson, G. D. (2012). *Log-linear analysis*. Asheboro, North Carolina: Statistical Publishing Associates.
- Homma, Y., Wang, N., Saewyc, E., & Kishor, N. (2012). The relationship between sexual abuse and risky sexual behavior among adolescent boys: A meta-analysis. *Journal of Adolescent Health*, 51(1), 18–24. doi:10.1016/j.jadohealth.2011.12.032
- Huey, S. J., Jr, Tilley, J. L., Jones, E. O., & Smith, C. A. (2014). The contribution of cultural competence to evidence-based care for ethnically diverse populations. *Annual Review of Clinical Psychology*, 10, 305–338. doi:10.1146/annurev-clinpsy-032813-153729
- Jones, D. J., Lewis, T., Litrownik, A., Thompson, R., Proctor, L. J., Isbell, P. & Runyan, D. (2013). Linking childhood sexual abuse and early adolescent risk behavior: The intervening role of internalizing and externalizing problems. *Journal Of Abnormal Child Psychology*, 41 (1), 139–150. doi:10.1007/s10802-012-9656-1
- Lee, C., Cronley, C., White, H. R., Mun, E. Y., Stouthamer-Loeber, M., & Loeber, R. (2012). Racial differences in the consequences of childhood maltreatment for adolescent and young adult depression, heavy drinking, and violence. *Journal of Adolescent Health*, 50 (5), 443–449. doi:10.1016/j.jadohealth.2011.09.014
- Messman-Moore, T. L., Walsh, K. L., & DiLillo, D. (2010). Emotion dysregulation and risky sexual behavior in revictimization. *Child Abuse & Neglect*, 34(12), 967–976. doi:10.1016/j.chiabu.2010.06.004
- Olafson, E. (2011). Child sexual abuse: Demography, impact, and interventions. *Journal Of Child & Adolescent Trauma*, 4(1), 8–21. doi:10.1080/19361521.2011.545811
- Rhodes, A. E, Boyle, M. H, Tonmyr, L, Wekerle, C, Goodman, D, Leslie, B, & Manion, I. (2011). Sex differences in childhood sexual abuse and suicide-related behaviors. *Suicide & Life-threatening Behavior*, 41(3), 235-254. doi: 10.1111/j.1943-278X.2011.00025.x

- Schraufnagel, T. J., Davis, K. C., George, W. H., & Norris, J. (2010). Childhood sexual abuse in males and subsequent risky sexual behavior: A potential alcohol-use pathway. *Child Abuse & Neglect, 34*(5), 369-378.
- Shapiro, D. N., Kaplow, J. B., Amaya-Jackson, L., & Dodge, K. A. (2012). Behavioral markers of coping and psychiatric symptoms among sexually abused children. *Journal of Traumatic Stress, 25*(2), 157-163. doi:10.1002/jts.v25.2
- Shin, S. H., Edwards, E. M., & Heeren, T. (2009). Child abuse and neglect: Relations to adolescent binge drinking in the national longitudinal study of adolescent health (AddHealth) Study. *Addictive Behaviors, 34*(3), 277-280. doi:10.1016/j.addbeh.2008.10.023
- Thompson, N. J., McGee, R. E., & Mays, D. (2012). Race, ethnicity, substance use, and unwanted sexual intercourse among adolescent females in the United States. *Western Journal of Emergency Medicine, 13*(3), 283. doi:10.5811/westjem.2012.3.11774
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). Child maltreatment 2012. Retrieved from <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment>.
- Wurtele, S. K. (2009). Child sexual abuse prevention: Preventing sexual abuse of children in the twenty-first century: Preparing for challenges and opportunities. *Journal of Child Sexual Abuse, 18*(1), 1-18. doi:10.1080/10538710802584650