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Ethnicity and Sexual Orientation as PTSD Mitigators in Child Sexual Abuse Survivors

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Purpose and Potential benefits: Research, to our knowledge, has not examined the effect of demographic variables on PTSD symptoms among adult survivors of childhood sexual abuse (CSA). This study explores the relationship between demographic variables and scores of CSA survivors on the Impact of Event Scale (IES). Participants were 257 women CSA survivors entering outpatient treatment at a university-based mental health center. All participants reported a CSA history and presented with psychological difficulties associated with CSA. The demographic variables investigated were relationship status, religious affiliation, ethnicity, educational level, spousal educational level income, and sexual orientation. Significance tests were used to examine each variable and scores on the Total IES and Avoidance and Intrusion Subscales. Total IES and Intrusion scores differed for sexual orientation and ethnicity in accord with conventional standards of significance ($\alpha < .05$). Self-reported asexuals indicated fewer intrusive and total PTSD symptoms than heterosexuals, lesbians, and bisexuals. Likewise, Hispanics reported less intrusive PTSD symptoms than Non-Hispanic Caucasians. Our findings invite further exploration of the relationship between ethnicity and sexual orientation and the long-term effects of CSA. A question for empirical investigation is whether asexuality shields against the triggering of CSA memories by a sexual relationship. Another possible area of inquiry is whether particular characteristics of Hispanic culture as a whole serve to moderate the detrimental effects of CSA.

KEY WORDS: child sexual abuse; demographics; PTSD; sexuality; sexual orientation.

INTRODUCTION

Empirical evidence suggests that childhood sexual abuse (CSA) is associated with a number of social and psychological adjustment problems in adulthood, including damage to self-perceptions and emotional reactions, relationship difficulties, problems with sexuality, and difficulties in social functioning (for a detailed review see: Beitchman *et al*., 1992; Cahill *et al*., 1991; Fleming *et al*., 1999). Symptoms of PTSD and depression have also been associated with CSA trauma (Bell & Belicki, 1998; Briere & Runz, 1987; Doxey *et al*., 1997). These findings may lead one to conclude that persistent psychosocial difficulties are an unfortunate and inevitable consequence of CSA. However, they do not necessarily indicate a causal relationship between CSA and psychosocial distress.

Investigators have searched for mitigating factors to the long-term effects of CSA. For example, researchers have looked at abuse characteristics (e.g., number of perpetrators, duration of the abuse, acts of the abuse, age of onset of the abuse, etc.) in an attempt to assess their possible impact on adult psychological functioning. Few CSA research studies, however, have examined the relationship between current adult demographic characteristics and psychological functioning. General demographic information that is nonspecific to the CSA trauma has typically been at the periphery of investigations of women with CSA histories. For example, relationship status, ethnic background, religion, SES, and educational level have more commonly been included in CSA research to protect

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against violations of internal validity rather than as direct foci of investigation.

Investigations of other traumatic events, however, have found that levels of psychological distress differ according to demographic variables. For example, the severity of PTSD symptomotology varied on general demographic variables nonspecific to the traumatic event among Cambodian refugees (Cheung, 1994), combat veterans (Bailey, 1997), victims of natural disaster (Garrison *et al*., 1995), and recent exiles to the United States (Ying, 1988).

Exploratory examination of demographic information among CSA survivors is important for the identification of potential buffers to the development of psychological distress as manifested by PTSD. The present investigation considers relationship status, religion, ethnicity, educational level, income, and sexual orientation as demographic variables that may be related to level of psychological distress. The form of psychological distress examined in this study is that of PTSD symptomatology as measured by scores on the Impact of Event (IES) scale.

Relationship Status

Research suggests that CSA is associated with problems with intimate relationships (Doxey *et al*., 1997; Finkelhor *et al*., 1989). Women with CSA histories are more likely to choose abusive partners (Beitchman *et al*., 1992; Messman & Long, 1996; Sappington *et al*., 1997), are more likely to divorce (Mullen *et al*., 1994), and are more likely to have never married or cohabitated (Bifulco *et al*., 1991) than women without CSA histories. Additional evidence indicates that CSA survivors are more vulnerable to psychological problems when their relationships are not going well and are better protected against such susceptibilities when the relationship is satisfying (Whiffen *et al*., 1994).

Of empirical interest is whether PTSD severity varies according to relationship status (i.e., single; currently in an intimate relationship; or previously in an intimate relationship that has since ended). Given the propensity of CSA survivors to have problematic intimate relationships, women with CSA histories who are single or uninvolved may avoid some of the daily demands of intimacy and, consequently, avoid intrusive PTSD symptomatology. For women with a history of CSA who are presently involved in relationships, intimacy may force a reliving of childhood trauma through expectations about sex or through the realization of a relationship of poor quality. Although the present investigation does not examine relationship quality, relationship status (i.e., simply "having" or "not having" a significant other) may be related to PTSD symptom severity and may indicate an area for further investigation.

Religion

Research suggests that the support of a religious affiliation following a sexual abuse experience may contribute to emotional stability (Valentine & Feinauer, 1993). A study of resilience factors among female survivors of CSA indicated that high functioning women cited religion or spirituality as a "very important" factor in providing support and the ability to overcome the abuse (Valentine & Feinauer, 1993). A finding of lower PTSD levels among CSA survivors of various faiths in comparison to those without a religious affiliation would support evidence of religion as a resiliency factor. In addition, this line of inquiry may suggest that differences in PTSD symptom severity can be accounted for by religious denomination. Such a finding would invite additional research seeking to identity characteristics of particular faiths that afford protection against psychological distress.

Ethnicity

According to Mennen (1995), "a child's race/ethnicity may influence the way the experience of sexual abuse is processed, the meaning of the abuse to the victim, and the severity and kinds of symptoms that develop" (p. 115). Mennen's supposition (Mennen, 1995) notwithstanding, the literature is inconclusive regarding the influence of ethnic background on the psychological remnants of abuse.

Phillips-Sanders *et al*. (1995) examined psychological distress, in the form of depression, among Hispanic and African American girls (ages 8–13) who presented with physical evidence of sexual abuse at an outpatient facility. The researchers found that depression appeared to be related to ethnicity. Hispanic girls reported poorer psychological functioning in terms of depression than African American girls. The authors speculated that social undermining (i.e., subversive social networks) in Latin culture may have, in part, accounted for greater depressive reactions among the Hispanic girls.

The findings of another study found the opposite to be the case. Among a community sample of women with a prior history of sexual and/or physical abuse, African American women reported more symptoms of depression and PTSD than their Hispanic and

Non-Hispanic Caucasian counterparts (Axelrod *et al*., 1999). Like Phillips-Sanders *et al*. (1995), the authors of this study suggested that psychological functioning was modified by greater social undermining. However, in this instance, it was supposed that African American culture, rather than Hispanic culture, maintained an undermining influence (Axelrod *et al*., 1999).

In contrast to the previous studies, an investigation of sexually abused girls and adolescents (ages 6–18) receiving outpatient treatment at a community mental health center failed to find a general effect of ethnicity. No differences were found among Hispanics, Non-Hispanic Caucasians, and African Americans on psychological distress in terms of depression, anxiety, or self-worth (Mennen, 1995).

The question of the impact of ethnicity on long-term effects of CSA is unclear, in part, because the literature lacks consistency with regard to sample characteristics and the form of psychological distress examined (e.g., PTSD vs. depression vs. anxiety, etc.). Exploratory analyses revealing an effect of ethnicity on PTSD symptoms in a clinical sample of CSA survivors would suggest an area for further inquiry in the arena of sexual abuse literature.

Education and Income

Research concerning CSA and social mobility is scarce (Cahill *et al*., 1991). To our knowledge researchers have not examined whether social mobility factors such as income and education level bear upon levels of psychological distress among CSA survivors. A starting off point in this vein of inquiry is the exploration of a relationship between education and income and PTSD symptoms as an indicator of psychological distress in response to CSA. Intuitively it seems that higher education level and income would afford opportunities and comforts that might serve as buffers to PTSD. In fact, there is evidence that suggests that among immigrants to the United States, the less educated and those with lower SES are more likely to be distressed as indicated by depression scales (Ying, 1988).

Sexuality

Finkelhor and Browne (1985) hypothesize that CSA survivors develop misconceptions about their bodies and distorted sexual morals as adults due to learning developmentally inappropriate sexual behaviors as children. For many women with CSA histories, sexual behavior was rewarded with affection, attention, privileges, and gifts (Finkelhor & Browne, 1985). Such reinforcement of sexuality in childhood may lead to heightened sexuality in adulthood. Research has found that CSA is associated with greater sexual drive and experience, a greater range of sexual fantasies, more liberal sexual attitudes, greater frequency of intercourse and masturbation, increased likelihood of engaging in unrestricted or nonaccepted sexual behaviors and fantasies, and higher numbers of unsafe sexual partners (Bartoi & Kinder, 1998; Meston *et al*., 1999; Walser & Kern, 1996).

Women with CSA histories may also suffer from feelings of guilt and shame imposed by childhood abusers or individuals with knowledge of the abuse (Finkelhor & Browne, 1985). Research indicates that women with CSA histories tend to be less satisfied with the quality of their most recent sexual relationship (Bartoi & Kinder, 1998), experience greater sex guilt (Walser & Kern, 1996), diminished sexual pleasure (McGuire & Wagner, 1978), and greater sexual dysfunction (Fleming *et al*., 1999; Wyatt, 1990) than women without CSA histories.

In short, research seems to suggest an enhanced propensity toward sexual experience among women with CSA histories but a diminished capacity for sexual adjustment. Of empirical interest is how sexuality, or the absence of a clear sexual preferene, bears upon psychological adjustment in terms of PTSD symptoms. For example, there is the question of whether PTSD symptom severity among CSA survivors of "uncertain" or "asexual" orientation is different from that of women of heterosexual, lesbian, or bisexual orientation. Correlates of a nonheterosexual orientation among women with CSA histories have not been explored in the literature (Cahill *et al*., 1991). Of interest, then, is whether sexual orientation is relevant to the study of the long-term effects of CSA.

Present Study

This investigation focuses on exploring possible relationships between present factors (demographics) and severity of PTSD symptomatology among a clinical sample of CSA victims. The demographic variables investigated were ethnicity, religion, relationship status, education level (of respondent and spouse), income, and sexual orientation.

METHOD

Participants

The participants were 257 women seeking outpatient psychotherapy at a university-based community mental

health center. The treatment program's services were provided at all three suburban locations of the university-based community mental health center, which serves a large metropolitan area in the southeastern United States. The main criteria for admission into the program were that the individuals had reached age 17, were reporting a history of CSA, and were presenting with the traumatic aftereffects of CSA.

Demographics

The sample ranged in age from 17 to 58, with a mean age of 32.13 ($SD = 9.16$). Of the total number of participants, 77% identified themselves as Caucasian, 10.2% as Hispanic, 7.4% as African American, and 5.5% of other ethnic backgrounds. The average level of education was 12.5 years ($SD = 2.23$). With respect to employment status, 35.3% of participants indicated that they were employed full time, 21.3% were employed part-time, and 43.4% were unemployed. Relationship status figures were as follows: 41.4% of the participants were married, engaged, or cohabitating (not engaged), 30.5% were single, and 28.1% were separated, divorced, or widowed. The participants reported the following annual incomes: 44.5% between $4,999 and 9,999, 30% between $10,000 and 19,999, 13% between $20,000 and 29,999; and 12.6% over $30,000. The mean age at onset of the abuse was 6.97 ($SD = 3.66$), average duration of the abuse was 5.07 years ($SD = 5.23$), and average the number of abuse perpetrators was 2.73 ($SD = 2.29$).

Instruments

Impact of Event Scale

The Impact of Event Scale (IES; Horowitz *et al*., 1979) is a self-report measure of subjective distress related to a specific event. The scale is composed of 15 questions designed to measure Intrusion, Avoidance, and Total Distress following a traumatic life event. Responses are recorded on a 4-point Likert scale representing the degree to which various symptoms were experienced during the prior week. Total scores on the IES have a possible range of 0 to 75. Horowitz (1982) indicated thresholds for clinical concern using the Total IES score: low, <8.5; medium, 8.6–19.0; and high, >19. In a review of the psychometric properties of the IES, Joseph (2000) reported that several studies have confirmed the satisfactory psychometric status of the scale. Joseph (2000) indicated that empirical evidence suggests that internal reliability of the IES (encompassing total score and subscales) ranges from Cronbach's $\alpha = .69$ to .88. Horowitz *et al*. (1979) reported an IES test–retest reliability of $r = .89$ for Intrusion and $r = .79$ for Avoidance over 1 week.

Structured Clinical Interview

Data were collected as part of a larger protocol for ongoing research in the sexual abuse survivors treatment program using a structured clinical interview with established reliability (Gold *et al*., 1996). The interview was structured so that participants with multiple abusers provided information pertaining to the molestation committed by each of their perpetrators, with a total of up to three perpetrators.

A previous study assessed the reliability for the instrument, based on a comparison of the interviewers' ratings and those of an independent rater listening to an audiotape of the interview for 25 separate participants (Gold *et al*., 1996). Pearson correlations were used to assess reliability for the continuous variables, yielding coefficients ranging from .971 to .985. Landis and Koch (1977) indicate that the Kappa statistics may be interpreted as follows: .00 poor; .01 to .20 slight; .21 to .40 fair; .41 to .60 moderate; .61 to .80 substantial; .81 to 1.00 almost perfect. Kappa coefficients for the categorical variables ranged from .42 to 1.00, with a median value of .80. For the instrument as a whole, more than 90% of the total number of categorical variables examined received coefficients in the substantial to perfect range. All but one of the categorical variables used in the present study yielded Kappa coefficients of over .61.

Procedure

The structured clinical interview and IES were administered by trained advanced doctoral student-clinicians comprising the staff of the sexual abuse survivors treatment program. Informed consent was obtained from each participant prior to administration. Participants were assured that treatment was not contingent upon research participation in any way. To minimize the effects of treatment on the data, the instruments were administered in the earliest session possible. Data were collected after the initial intake session in the instances in which: the client did not feel ready to respond to the interview questions or in cases for which the therapists judged that administration of the interview would cause undue stress for the client. However, in the majority of cases, the interview was completed very early in treatment, as 69.9% of the participants completed it during the initial intake

Table I. Mean IES Scores According to Demographic Variables ($N = 257$)

	IES total score			IES intrusion score			IES avoidance score		
Demographic	*M*	*SD*	*N*	*M*	*SD*	*N*	*M*	*SD*	*N*
Relationship status									
Single	45.14	15.30	78	19.03	9.42	78	26.28	8.35	77
Intimate relationship	45.82	16.51	106	20.71	9.65	105	25.43	8.93	104
Previous relationship	44.49	18.04	72	24.59	10.22	71	19.97	10.25	72
Income									
4,999–9,999	44.88	17.61	110	19.78	10.22	110	25.31	9.47	108
10,000–19,999	45.57	15.53	74	19.84	9.59	73	25.96	8.57	73
20,000–29,000	45.34	17.35	32	21.25	9.02	32	24.09	9.77	32
30,000 above	44.68	15.81	31	19.27	10.30	30	25.84	8.76	31
Education level									
High school or lower	45.56	14.70	18	18.00	10.20	18	27.56	6.40	18
College and higher	46.33	19.90	48	21.26	11.64	47	25.83	9.74	46
Spouse's education level									
High school or lower	49.53	12.60	13	21.62	9.63	13	27.92	6.63	13
College and higher	46.13	18.25	8	19.38	10.57	8	29.43	4.61	7
Religion									
Christianity	44.97	17.45	90	19.88	10.41	89	25.27	9.48	89
Judaism	46.31	17.11	16	20.38	20.38	16	27.13	6.89	15
Agnosticism/atheism	40.64	18.36	25	18.84	9.76	25	21.80	10.09	25
Sexual orientation									
Uncertain	49.67	9.42	6	22.33	7.42	6	27.33	6.83	6
Asexual	27.40	24.18	10	10.30	12.75	10	17.10	14.37	10
Bisexual	48.88	12.97	8	23.63	7.42	8	25.25	8.73	8
Lesbian	46.16	13.07	19	21.00	7.62	19	25.16	7.38	19
Heterosexual	45.78	16.28	212	20.18	9.70	210	25.87	8.91	209
Ethnicity									
African American/Black	42.05	15.32	19	18.56	10.53	18	23.61	11.16	18
Caucasian	46.52	16.30	197	20.91	9.45	196	25.78	8.88	196
Hispanic	38.96	17.18	26	15.42	10.38	26	24.16	8.94	25
Other[a]	42.50	18.75	14	17.14	9.65	14	25.36	10.49	14

[a]Other = Native American, Asian American, Multiracial, and other categories.

session, and 92.4% of them by the fifth therapy session. No gender differences were observed for intake completion time.

RESULTS

This study is exploratory in nature. The influence of several demographic variables on scores on the Total IES and subscales (i.e., Intrusion and Avoidance) were examined using a series of one-way, between groups ANOVAs. The demographic dimensions examined were ethnicity, religion, education level (of respondent and spouse), relationship status, income, and sexual orientation. Alpha probabilities were calculated for each analysis. Of all the analyses, only two variables produced alpha probabilities that fall into the conventional category of statistically significant results (<.05): Ethnicity on the Intrusion subscale of the IES, $F(3, 250) = 3.09$; $p = .027$ and sexual orientation, $F(4, 250) = 3.30$; $p = .0116$, on the Total IES and the Intrusion Subscales of the IES. The sample means and standard deviations of the variables are displayed in Table I.

Post-hoc comparisons revealed that Hispanics scored lower than non-Hispanic Caucasians on the Intrusion Subscale of the IES ($p < .0065$). Asexuals scored lower on the Total IES and the Intrusion Subscale of the IES than those who reported a particular sexual orientation. The following significance levels refer to comparisons with asexual orientation on the Total IES and the Intrusion subscale respectively: heterosexual ($p = .0403$ and $p = .0022$), lesbian ($p = .0417$ and $p = .0022$), bisexual ($p = .0384$ and $p = .0188$) and uncertain ($p = .0384$ and $p = .0188$).

DISCUSSION

The results of these exploratory analyses point to possible lines of inquiry for future research. First,

examination of the effect of ethnicity on PTSD severity may enable researchers to identify aspects of a particular ethnic background that serve to mitigate the long-term effects of CSA. Researchers have suggested that particular ethnic groups tend to undermine CSA survivors in culturally specific ways (Axelrod *et al*., 1999; Phillips-Sanders *et al*., 1995). However, the literature is inconclusive regarding which, if any, ethnic group maintains an undermining influence.

In this study, Hispanics reported less severe intrusive symptoms of psychological distress than did African Americans, Non-Hispanic Caucasians, and an "other" category of ethnic background. Although Hispanics had lower scores on the Total IES than CSA survivors of other ethnic groups, this difference did not reach significance. However, their scores were significantly lower than those of other ethnic groups on the Intrusion subscale of the IES. This result suggests a buffering effect of Hispanic ethnicity. This is in contrast to the findings of researchers who suggested that Hispanic culture marginalizes CSA survivors and thereby, may contribute to long-term psychological distress (Phillips-Sanders *et al*., 1995). A possible explanation for why the present findings contradict prior research is that in this study, as well as in previous investigations, the term "Hispanic" encompassed people of various nationalities. Hispanic ethnicity does not imply uniformity of culture. To better address the heterogeneity among Hispanics, and to more adequately disentangle the effects of ethnicity, researchers would do well to investigate CSA survivors of Hispanic origin according to ethnic identity. For example, a study examining the impact of immigration among Cuban exiles found that several demographic variables predicted higher levels of distress on the IES (Andres, 1998). The patterning and severity of distress responses in the Cuban sample differed from a similar investigation examining the distress responses on the IES of Salvadoran refugees (Plante *et al*., 1995). Although these investigations highlight the need to address heterogeneity among Hispanic cultural groups, important similarities may also exist. Researchers have pointed to the expansive social support networks maintained by Hispanics in general, and have suggested that greater social support among Hispanics may serve to mitigate psychological distress in response to a traumatic event (Griffith, 1985). Our findings suggest that future research should examine the question of how Hispanic ethnicity may serve to buffer PTSD symptoms among CSA survivors.

The second issue that should be addressed by future research is that of how sexual orientation factors into the question of the long-term effects of CSA. In this study, an asexual orientation, that is, a reported lack of interest in sex and, therefore, the absence of any particular sexual preference, seemed to account for lower Intrusion and Total IES scores. A possible explanation for this finding is that women without an interest in sex are unlikely to be exposed to sexual experiences that might trigger PTSD symptoms. Support for this interpretation comes from the finding of greater distress among those struggling with their own sexual identity. Although not statistically significant, there was a trend toward higher scores on the IES among respondents who were uncertain about their sexual orientation in comparison to those who identified themselves as asexual. Perhaps those who were uncertain about their sexuality were more distressed than those who identified themselves as asexual because they were actively confronting and grappling with the question of sexual identity.

Limitations of this study invite caution concerning interpretation of the results and generalization to other populations. Statistical correction for multiple tests is recommended when several variables are being examined to guard against spurious findings of significance. This study was exploratory in nature, and consequently examined several variables at once without regard to safeguarding against Type I error. Therefore, the findings should be interpreted in terms of indicating a direction for future investigation rather than as suggesting true differences. Furthermore, the findings of this study may not be generalizable to women with CSA histories outside of treatment because this study focused on women who were currently seeking treatment for CSA. Given these limitations and the exploratory nature of this research, these findings must be considered preliminary.

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