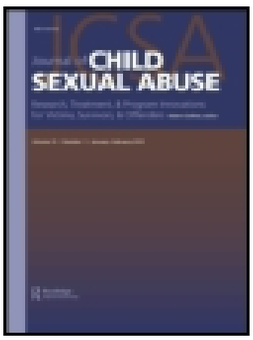

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ARTICLE

The Implications of Self-Definitions of Child Sexual Abuse for Understanding Socioemotional Adaptation in Young Adulthood

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ABSTRACT

This study examined associations between child sexual abuse (CSA) survivors' self-definition status (i.e., whether or not survivors self-identified as sexually abused) and multiple measures of psychopathology, self-system functioning, and risk behaviors. We evaluated the hypothesis that survivors with concordant abuse perceptions (i.e., individuals who reported objective CSA and self-defined as sexually abused) would evidence more pronounced adjustment difficulties in young adulthood than survivors with discordant perceptions (i.e., individuals who reported objective CSA but did not self-define as sexually abused). In this large and ethnically diverse college student sample (N = 2,195; 63.8% female, 36.2% male; 83.3% nonwhite), objective experiences of CSA were associated with increased psychopathology, decreased self-system functioning, and increased risk behaviors, but the magnitude of these effects varied by survivors' self-definition status. Relative to their nonmaltreated peers, survivors with concordant abuse perceptions evidenced the largest elevations in psychopathology and risk behaviors, whereas survivors with discordant abuse perceptions evidenced the largest deficits in self-system functioning. These findings indicate that standard screening criteria may misidentify a sizable group of CSA survivors because these individuals do not perceive their experiences as "abuse." Efforts to understand the meaning ascribed to CSA experiences may profitably guide clinical interventions to enhance specific domains of functioning.

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Child sexual abuse; abuse perception; self-definition status; young adult adjustment; effect sizes

Research consistently documents negative effects of child sexual abuse (CSA) on child development and adult adjustment (Hillberg et al., 2011), despite the complexities of operationally defining and assessing CSA (Mathews & Collin-Vézina, 2019). Although research has moved beyond broad stroke demonstrations of maladaptive CSA effects to clarify whether and how different features of CSA (e.g., chronicity, perpetrator identity) contribute to specific negative outcomes (Lange et al., 1999), little attention has been directed toward understanding how a survivor's subjective perception of whether or not they have been sexually abused may impact later functioning.

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This study examined associations between reported experiences of CSA and socioemotional adjustment in a large and ethnically diverse college student sample to evaluate the expected influence of CSA survivors' self-definition status (i.e., whether or not individuals who endorsed objective CSA experiences also identified as having been sexually abused) on young adult adjustment outcomes.

Defining CSA

CSA is notoriously difficult to define and evaluate (Haugaard, 2000; Mathews & Collin-Vézina, 2019). Many studies define CSA as any sexual contact between a child under the legal age of consent, which ranges from 16 to 18 in the United States, and someone significantly older than the child (e.g., five or more years; Tyler, 2002), whereas others include non-contact sexual activity (e.g., pornography exposure; Briere, 1992; Finkelhor et al., 2015). Some researchers consider the child's degree of willingness to participate in the activity irrespective of age as a potentially important feature of the experience (Rind et al., 1998), while others suggest children under the legal age of consent should be understood as having no or diminished capacity to provide true consent to sexual activity. Some studies limit definitions of CSA to sexual contact between a child and an adult (MacMillan et al., 1997), yet others also consider the perpetrator's stage of development and position of power or responsibility over the child (Mathews & Collin-Vézina, 2019). Most literature characterizes sexual contact between a child and someone five or more years older as CSA, regardless of the child's apparent willingness to participate or the perpetrator status as a minor or adult. Thus, this study examined relations between *objective* CSA, which we defined as behaviorally specific descriptions of sexual contact between a child under the age of 17 and a person five or more years older, and young adult adjustment outcomes, with the additional goal of examining the significance of survivors' *subjective* self-definition of these CSA events as abusive (i.e., concordant CSA group) or not abusive (i.e., discordant CSA group).

Phenomenology of CSA

Studies have explored gender and, to a lesser degree, ethnic-racial patterns in the phenomenology and developmental impact of CSA. Women are overrepresented among CSA survivors and, by extension, in CSA research (see Alaggia & Millington, 2008; Gagnier & Collin-Vézina, 2016 for exceptions). CSA prevalence rates range from 15% to 25% among females and 5–15% among males (Finkelhor et al., 2015; Stoltenborgh et al., 2011), and recent research suggests rates may be much higher among transgender and gender nonconforming groups (Tobin & Delaney, 2019).

Extant findings regarding the prevalence of CSA across ethnic-racial groups are mixed. In some samples, white females endorse more prolonged and severe periods of CSA than their nonwhite counterparts (Mennen, 1995). However, other studies find the highest rates and severity of CSA among Black and Latinx women (Kalof, 2000; Ullman & Filipas, 2005). Some data suggest that Latinx survivors report higher rates of intrafamilial CSA perpetration, whereas Black survivors report more attempted or completed penetration (Kalof, 2000). Unfortunately, research on CSA among Asian ethnic-racial groups is lacking (Back et al., 2003), though some data point to somewhat lower rates of CSA among Asian respondents (Ullman & Filipas, 2005).

Young adult adjustment following CSA

CSA is associated with enduring and varied negative developmental outcomes (Hillberg et al., 2011). However, studies examining relations between CSA and multiple domains of adaptation within a single investigation are rare. Few studies have examined CSA effects across sociodemographic groups, and fewer still have considered the influence of survivors' subjective self-definitions of objective CSA experiences as abuse (i.e., concordant perception) or not abuse (i.e., discordant perception) on relations between CSA and adaptive outcomes. This study filled these gaps by drawing on a large, mixed gender, ethnically diverse college student sample to examine the phenomenology and developmental sequelae of CSA as a function of survivors' abuse perceptions, gender, and ethnicity/race. Specifically, we evaluated associations between reports of objective CSA experiences and psychosocial adjustment across three core domains: 1) psychopathology, 2) self-system functioning, and 3) high-risk behaviors.

CSA disrupts fundamental systems of adaptation, including emotion regulation and the integration of cognition and affect. Compensatory regulatory strategies, such as dissociation, may support coping in the context of trauma, but undermine adjustment in later development (Carlson et al., 2009). The adverse effects of CSA may accumulate over time as earlier events (and adaptations) impede successful encounters with later challenges leading to psychopathology (Cicchetti, 2016; Hillberg et al., 2011). Thus, this investigation examined psychosocial adjustment among young adult survivors of CSA across multiple indices of psychopathology, including subjective distress, emotion dysregulation, and reactive anger.

The self-system is a key domain for identifying (and understanding) the effects of CSA (Westen, 1994). Research indicates that CSA negatively affects self-system functioning as evidenced by marked alterations in self-concept (Murthi et al., 2006) and the fragmentation of self-representation (Calverly et al., 1994). It is not yet clear whether some aspects of the self-system are more vulnerable than others to the adverse effects of CSA, or as a function of the

meaning-making that accompanies it (Downs, 1993). This study examined associations between CSA and multiple indices of self-system functioning, including self-efficacy, self-concept, and self-esteem.

Risk behaviors constitute a third domain of adaptation that is central to studies of CSA effects. Maltreatment researchers consistently find elevated rates of behavioral and conduct problems among maltreatment survivors, including involvement with drugs and alcohol (Harrison et al., 1997), criminal behavior (Kaufman & Widom, 1999), and sexual risk-taking (Cooper et al., 1998). Given the relational distortions associated with CSA, we selected three domains of risk behaviors that primarily affect the self (i.e., substance use), others (i.e., criminality), and self-with-others (i.e., sexual risk-taking).

Survivors' perceptions of CSA

This study evaluated young adult adjustment as related to objective CSA experiences *and* survivors' subjective self-definition of their experiences as "abuse." Although studies have explored relations between CSA characteristics and adult outcomes (Lange et al., 1999), and others have examined the effect of labeling sexual experiences as "unwanted" in adulthood (Harned, 2004), this study contributed new information about how a survivor's self-definition status as having (or not having) been "abused" may shape young adult adjustment outcomes.

Prior research suggests that experiences involving force and penetration, younger age of onset, and intrafamilial perpetration increase the likelihood that a CSA survivor will define their experiences as "abuse" in young adulthood (Stander et al., 2002). Extant findings regarding self-defined abuse status and adjustment are equivocal with some evidence that CSA perception does not significantly impact adjustment (Wekerle et al., 2001), other data showing that researcher-defined CSA is associated with more severe outcomes than survivor-defined CSA (Silvern et al., 2000), and still other studies finding variation in abuse perception (and in its relation to adjustment) over time (Goldsmith et al., 2009) or in relation to varied outcomes (Vaillancourt-Morel et al., 2016).

The capacity to make meaning of experiences and integrate them into extant belief systems is a powerful influence on adaptation in the face of adversity (Sanderson et al., 2016). In the case of CSA, however, children are placed in an untenable position that is, by definition, incompatible with normative beliefs and assumptions about how the world should work (e.g., adults provide care and protection for children; Janoff-Bulman, 2010). Survivors of CSA who self-identify as sexually abused must acknowledge that their world is dangerous and unpredictable, as are those from whom they would naturally seek comfort and protection. However, survivors of CSA who do not self-identify as sexually abused face equally pernicious challenges

as they must contrive an alternate experiential narrative – perhaps one in which they are personally responsible for the offender's actions. As with other coping mechanisms, abuse denial may be self-protective in the moment and contribute to lower levels of apparent pathology (even in comparison to nonmaltreated peers; Elliott & Briere, 1994), but it is likely to cause difficulties in later development. Thus, although we hypothesized that objective reports of CSA would be negatively associated with young adults' multi-domain adaptation, we further anticipated these effects would vary between survivors who endorsed having been sexually abused (i.e., concordant perception) versus those who did not (i.e., discordant perception).

This investigation examined the phenomenology of CSA (i.e., age of onset, perpetrator identity, and presence of force and/or penetration) and relations between CSA and maladaptation across select measures of psychopathology, self-system functioning, and risk behaviors in a large and ethnically diverse college student sample. As in prior research, we expected to find significant rates of CSA in this sample, particularly among females, but trends across ethnic-racial groups were exploratory. We predicted that a history of CSA would relate to negative outcomes, including increased psychopathology, decreased self-system functioning, and increased risk behaviors. However, we expected these relations to vary as a function of survivors' self-definition status. Consistent with prior research-examining perceptions of other forms of maltreatment, such as physical abuse (Carlin et al., 1994), we hypothesized that participants who self-defined their CSA experience as abuse (i.e., concordant CSA group) would endorse higher levels of maladaptation in young adulthood than those who considered their CSA experience to be non-abusive (i.e., discordant CSA group).

Method

Participants

Participants were undergraduate students drawn from a study of psychosocial adaptation at a large, public four-year university in southern California (N = 2195; 63.8% female; 36.2% male, M_{age} = 19.15, SD = 1.52). The total sample was 46.2% Asian, 27.1% Latinx, 16.7% white, 6.6% Black, and 3.5% Multiracial or other ethnicity-race, and representative of the university population from which they were drawn (i.e., 37.7% Asian, 23.7% Latinx, 20.1% white, 6.7% Black, 5.2% Multiracial or other ethnicity-race, and 6.5% unknown). The current investigation included participants who reported objective CSA and self-identified as sexually abused (N = 193; i.e., concordant CSA group), those who reported objective CSA but did not self-identify as sexually abused (N = 59; i.e., discordant CSA group), and those who reported no childhood maltreatment (N = 1202; i.e., nonmaltreated comparison group). The remaining

741 participants endorsed other forms of maltreatment (e.g., physical abuse) and were excluded from all analyses.

Procedure

Participants were recruited from introductory psychology courses and received class credit in exchange for their completion of a 2-hour computerized survey. Students were informed that the purpose of the study was to examine relations between adaptation in young adulthood and various experiences in childhood and adolescence, including difficult life events. They were assured that their participation was anonymous and no personally identifying information was collected. Participants completed the survey in small groups of up to 14 students using private cubicles in a laboratory setting under the supervision of a trained research assistant. Each participant was required to stay for the full 2-hour survey period to minimize the incentive to rush through the questionnaires. Surveys were password-protected and administered through a computerized survey management company. Responses were carefully monitored for completeness and the information was encrypted (until download) and identified by a code number to further ensure the security of the data. All procedures were reviewed and approved by the Human Research Review Board of the participating university.

Measures

Childhood maltreatment

CSA

CSA was measured using the Short Form of the Childhood Maltreatment Interview Schedule (Briere, 1992). The full measure demonstrates effectiveness at discriminating among long-term outcomes of various maltreatment subtypes (Briere & Runtz, 1990), and the Short Form has been used in ways similar to this investigation (e.g., McNutt et al., 2002). In a computerized interview, participants reported on the form and frequency of CSA using objective behavioral descriptors. Participants were first asked: *Before the age of 17, were you ever touched in a sexual way that made you uncomfortable, when you did not want to be, or at a time when you couldn't defend yourself?* If participants answered affirmatively, they were prompted to answer questions regarding the identity and relatedness of the perpetrator, age of onset, age of perpetrator, and whether there was physical force or penetration. All questions were asked for each perpetrator identified by the participant. Objective CSA was defined as any sexual experience that involved physical contact with someone who was 5 or more years older than the participant. Unwanted

sexual contact between a child and another child who was less than 5 years older (e.g., an 11-year-old and a 14-year-old) was considered peer sexual assault and was not defined as CSA in this study. Sexual contact between an adolescent and an adult who was less than 5 years older (e.g., a 15-year-old and an 18-year-old) was considered statutory rape and was not defined as CSA in this study.

CSA self-definition

At the close of the CSA interview, participants were asked: *To the best of your knowledge, before the age of 17, were you sexually abused?* This final question was used to identify a concordant self-defined CSA group (i.e., endorsed objective CSA and self-defined their experience as abuse; N = 193) and a discordant self-defined CSA group (i.e., endorsed objective CSA and did *not* self-define their experience as abuse; N = 59).

Nonmaltreated comparison group

In addition to CSA, Briere's (1992) Child Maltreatment Interview probed for domestic violence exposure, physical abuse, and emotional abuse. Individuals who endorsed a history of domestic violence exposure (i.e., having seen or heard one parent hit or beat up the other parent), physical abuse (i.e., being hit, pushed, punched, or cut by a caregiver on purpose and causing injury), and/or who scored in the top 10% of the emotional abuse scale (i.e., frequency of being yelled at, insulted, criticized, threatened, or humiliated by a caregiver) were considered maltreated (N = 741) and were excluded from the nonmaltreated comparison group (N = 1202) and all analyses.

Psychopathology

Emotion regulation was assessed with the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004), which consists of 36 items (e.g., "when I'm upset, I feel out of control") that are rated on a 5-point scale from 1 (*almost never or 0–10% of the time*) to 5 (*almost always or 91–100% of the time*). The DERS shows strong internal consistency in college populations and good construct validity (Sloan & Kring, 2007). The sum of emotion regulation difficulties was used in these analyses and demonstrated adequate reliability (α = .85).

Subjective distress was assessed with the Symptom Checklist 90 Revised (SCL-90-R; Derogatis, 1983), which consists of 90 symptoms (e.g., crying easily, trouble concentrating) that are rated on a 5-point scale from 0 (*having caused no discomfort*) to 4 (*having caused extreme discomfort*) during the past week. The SCL-90-R evidences good test–retest reliability and internal consistency across varied samples (Derogatis, 1983). The sum of anxiety (14 items, α = .91) and depression (17 items, α = .92) scales indicated participants' subjective distress.

Anger was assessed with the State-Trait Anger Inventory (STAXI; Spielberger et al., 1983), which includes 6 items (e.g., "I feel like hitting someone when frustrated," α = .80) rated from 1 (*almost never*) to 4 (*almost always*). The STAXI has shown good internal consistency and reliability in previous work (Spielberger et al., 1983).

Self-system functioning

Self-efficacy was assessed with the Global Self-Efficacy Scale (Sherer et al., 1982), which consists of 17 items (e.g., "If I can't do a job the first time, I keep trying until I can") that are rated on a 5-point scale from 1 (*disagree strongly*) to 5 (*agree strongly*). This measure demonstrated good internal consistency in the current sample (α = .86), which is consistent with the original α = .86 reported in the construction and validation of the scale (Sherer et al., 1982).

Self-concept was assessed with the Self-Perception Profile for College Students (Neeman & Harter, 1986), which includes 54 items that evaluate perceived competence in cognitive, social, and physical domains. Participants indicated which of two phrases (e.g., "some students like the kind of person they are" or "other students wish that they were different") best described them and indicated whether the statement was "sort of true" or "really true." The total self-worth scale was used in these analyses. This scale had strong internal consistency in this sample (α = .93), and evidenced good reliability in prior studies (Masciuch et al., 1990).

Self-esteem was assessed with the Index of Self-Esteem (ISE; Hudson, 1982), which consists of 25 items (e.g., "when I am with others, I feel they are glad I am with them") that are rated from 1 (*rarely or none of the time*) to 5 (*most or all of the time*). This measure has good test–retest reliability (r = .92; Hudson, 1982), internal consistency (α = .95 in the current study), and discriminant validity (r = .78; Abell et al., 1984).

Risk behaviors

Risk behaviors were measured using items drawn from the Adolescent Health Survey (AHS; Blum et al., 1989). First, substance use was indicated by the total frequency of problems caused by the participant's substance as summed across 10 yes/no items that followed the prompt, "In the past year, have you ever had any of the following problems from drinking or drug use" (e.g., an accident or injury, work-related problems, becoming violent, family/friend-related problems). Second, criminal behavior was indicated by the total frequency of criminal behaviors summed across14 yes/no items that asked whether or not the participant had engaged in various criminal activities, regardless of arrest or conviction (e.g., vandalism, robbery, assault, arson, homicide). Third, risky sexual behavior was indicated by a composite of 1) sexual activity before age

16 (i.e., yes or no), 2) infrequent or absent birth control use (i.e., a rating of infrequent or never), and 3) three or more prior sexual partners. The AHS has demonstrated adequate reliability and internal consistency in prior studies (Blum et al., 1989).

Data preparation & analytic plan

Chi-square analyses evaluated gender and ethnic-racial differences across categorical maltreatment groups (i.e., concordant CSA, discordant CSA, and nonmaltreated), as well as differences in abuse characteristics (i.e., perpetrator identity, age of onset, use of physical force, penetration) across the concordant and discordant CSA groups. All participants in the concordant CSA group, discordant CSA group, and nonmaltreated comparison group were assessed on all adjustment variables (i.e., psychopathology, self-system functioning, and risk behaviors). A multivariate analysis of variance (MANOVA) evaluated mean differences in young adult adjustment outcomes by participant gender, ethnicity-race, and their interaction. Independent samples *t*-tests evaluated mean differences between those who endorsed a history of CSA and those with no maltreatment history. Planned contrast tests evaluated the hypothesis that concordant CSA survivors would show poorer adjustment than discordant CSA survivors, and discordant CSA survivors would show poorer adjustment than nonmaltreated participants.

Planned contrast *p*-values were adjusted to control for the false discovery rate (FDR), which is the expected proportion of type I errors. The FDR approach is an alternative to family-wise error rate corrections, such as the Bonferroni correction. The FDR controls for the expected proportion of false positives, rather than guarding against making *any* false-positive conclusions, which allows for both increased statistical power and fewer type I errors (Benjamini & Hochberg, 1995). Following contrast analyses, effect sizes and confidence intervals quantified the magnitude of mean differences between the concordant CSA and nonmaltreated groups, and between the discordant CSA and nonmaltreated groups across measures of psychopathology, self-system functioning, and risk behaviors. Cohen's (1988) *d* values were calculated to evaluate the degree of CSA impact as a function of concordant versus discordant abuse self-definition with small, medium, and large effects indicated by values of .2, .5, and .8, respectively.

Results

CSA phenomenology

Frequencies of CSA and participants' CSA self-definition groups by gender and ethnicity-race are reported in Table 1. As shown in Table 1, 11.5% (*N* =

Table 1. Frequencies of CSA, CSA Perception, and Nonmaltreated Status by Gender and Ethnicity-Race.

	Asian		Latinx		White		Black		Other		Total	
CSA	**25.4%** **(64)** *89.1%* *(57)* 10.9% (7)		**41.3%** **(104)** *86.5%* *(90)* 13.5% (14)		**19.0%** **(48)** *93.8%* *(45)* 6.2% (3)		**10%** **(25)** *100%* *(25)* - -		**3.6%** **(9)** *88.9%* *(8)* 11.1% (1)		**100%** **(252)** *90.1%* *(227)* 9.9% (25)	
Percept.	Concord.	Discord.	Concord.	Discord.	Concord.	Discord.	Concord.	Discord.	Concord.	Discord.	Concord.	Discord.
	78.1% **(50)** *77.2%* *(44)* 85.7% (6)	**21.9%** **(14)** *22.8%* *(13)* 14.3% (1)	**76.9%** **(80)** *78.9%* *(71)* 64.3% (9)	**23.1%** **(24)** *21.1%* *(19)* 35.7% (5)	**75.0%** **(36)** *73.3%* *(33)* 100% (3)	**25.0%** **(12)** *26.7%* *(12)* - -	**68.0%** **(17)** *68.0%* *(17)* - -	**32.0%** **(8)** *32.0%* *(8)* - -	**100%** **(9)** *100%* *(8)* 100% (1)	- - -	**76.6%** **193** *77.0%* *(174)* 76.0% (19)	**23.4%** **59** *23.0%* *(52)* 24.0% (6)
Non-Maltreat.	**49.5%** **(592)** *53.9%* *(319)* 46.1% (273)		**25.5%** **(305)** *60.7%* *(185)* 39.3% (120)		**17.0%** **(203)** *60.4%* *(122)* 39.6% (80)		**5.4%** **(65)** *72.3%* *(47)* 27.7% (18)		**2.6%** **(31)** *67.7%* *(21)* 32.3% (10)		**100%** **1202** *58.2%* *(696)* 42.1% (504)	

Total sample (top, bold), females (middle, italics), males (bottom). 16 participants were missing data on sex (n = 8) and/or ethnicity-race (n = 13

252) of the total sample reported one or more objective CSA experiences, with higher rates of 16.3% (N = 227) among females as compared to 3.2% (N = 25) among males, $\chi^2(1) = 88.12$, $p < .001$. An additional 5.1% of the total sample (N = 112; 86 females and 26 males) endorsed other sexual events in childhood, but were excluded from both the CSA and nonmaltreated groups on the basis of peer-based sexual assault and/or ambiguity as to the perpetrator's age. Of the 252 participants who endorsed objective CSA, 76.6% (N = 193; 174 females and 19 males) self-defined as having been sexually abused (i.e., concordant CSA group), and 23.4% (N = 59; 52 females and 7 males) did not self-define as having been sexually abused (i.e., discordant CSA group). In the total sample of CSA survivors (i.e., concordant and discordant CSA groups), 36.5% (N = 92) reported CSA perpetrated by a family member (the majority of whom were extended family), 19% (N = 48) reported that there was physical force used, and 34.1% (N = 86) reported that penetration occurred. The only significant difference between the concordant and discordant CSA groups was that the age of CSA onset was more likely to be after age 6 in the discordant CSA group, $\chi^2[2] = 8.99$, $p < .05$. There were no significant gender differences in CSA characteristics between females and males within or across the concordant and discordant CSA groups.

Of the 252 individuals who reported CSA, 19% (N = 48) were white, 9.9% (N = 25) were Black, 41.3% (N = 104) were Latinx, 25.4% (N = 64) were Asian, and 3.6% (N = 9) endorsed other ethnic-racial identities (see Table 1). Asian participants endorsed significantly lower rates of CSA (6.6%) than all other ethnic-racial groups, $\chi^2[4] = 54.04$, $p < .001$. With respect to patterns of CSA self-definition, however, there were no significant differences in rates of concordance versus discordance across ethnic-racial groups. Among white survivors, 75% (N = 36) perceived their CSA as abusive (i.e., concordant), as did 68% (N = 17) of Black survivors, 76.9% (N = 80) of Latinx survivors, 78.1% (N = 50) of Asian survivors and 100% (N = 9) of survivors from other ethnic-racial groups. CSA characteristics did not differ significantly across groups, except that Latinx participants endorsed higher rates of intra-familial perpetration than other ethnic-racial groups, $\chi^2[8] = 23.944$, $p < .01$.

CSA and young adult adjustment

Table 2 depicts the means and standard deviations for subjective distress, emotion dysregulation, anger, self-efficacy, self-concept, self-esteem, substance use, criminal activity, and risky sexual behavior by gender and ethnicity-race. A MANOVA revealed significant main effects for gender (Wilks' $\lambda = 0.95$, F [9, 1253] = 7.42, $p < .001$), ethnicity-race (Wilks' $\lambda = 0.89$, F [36, 4697.31] = 4.22, $p < .001$), and their interaction (Wilks' $\lambda = 0.95$, F [36, 4697.31] = 1.87, $p < .001$). Females endorsed higher levels of subjective distress (F [1, 1261] = 12.75, $p < .001$) and emotion dysregulation (F [1, 1261] = 13.17, $p < .001$) than males, and males

Table 2. Means and Standard Deviations for Total Sample (top, bold), Females (middle, italics) and Males (bottom).

		Asian		Latinx		White		Black		Other		Total	
		Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)	Mean	(SD)
Psychopathology	Distress	**7.04**	**(7.77)**	**6.35**	**(7.23)**	**6.35**	**(7.37)**	**6.00**	**(7.61)**	**7.81**	**(7.36)**	**6.68**	**(7.53)**
		7.42	*(7.77)*	*7.28*	*(7.70)*	*7.31*	*(7.69)*	*6.00*	*(7.68)*	*9.37*	*(7.84)*	*7.32*	*(7.73)*
		6.45	(7.76)	3.90	(5.09)	4.01	(5.95)	5.96	(7.52)	4.89	(6.92)	5.38	(6.92)
	Emotion Dysregulation	**87.21**	**(20.62)**	**82.78**	**(22.95)**	**79.38**	**(24.14)**	**79.39**	**(23.32)**	**87.77**	**(22.90)**	**84.06**	**(22.42)**
		87.48	*(20.98)*	*84.86*	*(23.86)*	*81.38*	*(25.26)*	*81.94*	*(23.65)*	*90.53*	*(25.43)*	*85.19*	*(23.20)*
		86.80	(20.09)	77.34	(19.46)	74.54	(20.54)	68.25	(18.63)	82.57	(16.63)	81.75	(20.58)
	Anger	**12.44**	**(3.62)**	**11.61**	**(3.84)**	**11.77**	**(3.57)**	**11.56**	**(3.87)**	**13.16**	**(3.40)**	**12.06**	**(3.70)**
		12.00	*(3.45)*	*11.64*	*(3.93)*	*11.41*	*(3.30)*	*11.96*	*(3.82)*	*13.22*	**(3.28)**	*11.82*	*(3.61)*
		13.10	(3.78)	11.54	(3.62)	12.66	(4.04)	9.81	(3.69)	13.06	**(3.72)**	12.54	(3.45)
Self-System	Self-efficacy	**41.97**	**(6.94)**	**44.81**	**(7.42)**	**45.53**	**(7.36)**	**44.34**	**(7.17)**	**43.29**	**(7.54)**	**43.61**	**(7.34)**
		41.77	*(6.72)*	*44.29*	*(7.36)*	*44.98*	*(7.05)*	*44.15*	*(7.24)*	*44.04*	*(6.47)*	*43.42*	*(7.13)*
		42.27	(7.26)	46.15	(7.43)	46.85	(7.96)	45.18	(7.00)	41.88	(9.29)	44.00	(7.73)
	Self-concept	**149.94**	**(24.88)**	**155.89**	**(25.86)**	**161.56**	**(25.39)**	**163.71**	**(24.38)**	**152.58**	**(24.81)**	**154.73**	**(25.66)**
		149.78	*(24.78)*	*153.04*	*(26.71)*	*159.36*	*(25.50)*	*162.73*	*(24.50)*	*149.95*	*(25.49)*	*153.65*	*(25.83)*
		150.20	(25.09)	163.32	(21.96)	166.90	(24.49)	168.06	(24.11)	157.54	(23.39)	156.92	(25.18)
	Self-esteem	**119.45**	**(22.73)**	**128.72**	**(24.34)**	**132.62**	**(24.10)**	**134.29**	**(26.00)**	**119.86**	**(23.98)**	**125.42**	**(24.39)**
		120.68	*(22.83)*	*128.71*	*(25.09)*	*132.00*	*(23.96)*	*134.43*	*(24.27)*	*118.14*	*(26.01)*	*126.28*	*(24.51)*
		117.59	(22.51)	128.73	(22.37)	134.13	(24.56)	133.67	(33.49)	123.08	(24.10)	123.68	(24.09)
Risk Behaviors	Substance use Problems	**.43**	**(1.02)**	**.34**	**(.93)**	**.42**	**(1.03)**	**.14**	**(.54)**	**.47**	**(1.31)**	**.38**	**(.98)**
		.36	*(.92)*	*.37*	*(1.01)*	*.41*	*(1.03)*	*.13*	*(.48)*	*.66*	*(1.58)*	*.36*	*(.97)*
		.54	(1.14)	.26	(.68)	.42	(1.03)	.19	(.75)	.12	(.33)	.42	(1.00)
	Criminality	**1.10**	**(1.42)**	**.89**	**(1.16)**	**.97**	**(1.30)**	**.59**	**(.75)**	**1.67**	**(2.05)**	**1.01**	**(1.34)**
		.81	*(1.08)*	*.73*	*(1.06)*	*.86*	*(1.24)*	*.63*	*(.77)*	*1.13*	*(1.21)*	*.79*	*(1.21)*
		1.54	(1.73)	1.32	(1.30)	1.24	(1.39)	.38	(.62)	2.71	(2.82)	1.44	(1.65)
	Risky Sexual Behaviors	**.58**	**(.77)**	**.55**	**(.75)**	**.57**	**(.90)**	**.74**	**(.88)**	**.65**	**(.81)**	**.58**	**(.80)**
		.53	*(.75)*	*.52*	*(.77)*	*.57*	*(.93)*	*.70*	*(.93)*	*.64*	*(.80)*	*.55*	*(.81)*
		.65	(.80)	.62	(.68)	.55	(.83)	.90	(.65)	.66	(.87)	.64	(.78)

endorsed higher levels of self-concept (F [1, 1261] = 7.36, $p < .01$) and criminal activity (F [1, 1261] = 26.15, $p < .001$) than females. Follow-up univariate ANOVAs revealed significant differences by ethnicity-race for emotion dysregulation (F [4, 1261] = 9.52, $p < .001$), anger (F [4, 1261] = 5.65, $p < .001$), self-efficacy (F [4, 1261] = 15.33, $p < .001$), self-concept (F [4, 1261] = 13.65, $p < .001$), self-esteem (F [4, 1261] = 17.56, $p < .001$), and criminal activity (F [4, 1261] = 7.98, $p < .001$). FDR-corrected post-hoc comparisons indicated that Asian participants endorsed significantly more emotion dysregulation and lower self-efficacy, self-concept, and self-esteem than white, Black, and Latinx participants. Asian respondents also endorsed significantly more reactive anger than Latinx respondents. Two significant ethnicity-race by gender interactions emerged. First, white males and Black females reported higher levels of anger than other groups (F [4, 1261] = 3.60, $p < .01$). Second, males in all ethnic-racial groups (except Black males) and Black females reported higher levels of criminal activity (F [4, 1261] = 3.73, $p < .01$).

Independent samples t-tests between participants who endorsed CSA (i.e., combined concordant and discordant groups) and those who did not endorse maltreatment revealed higher rates of psychopathology among CSA survivors, including subjective distress (t [1355] = 9.27, $p < .001$), emotion dysregulation (t [1448] = 6.95, $p < .001$), and anger (t [1447] = 5.14, $p < .001$) than among their nonmaltreated peers. Within the domain of self-system functioning, CSA survivors endorsed significantly lower levels of self-efficacy (t [1442] = −2.56, $p < .05$) and self-concept (t [1431] = −3.96, $p < .001$) than nonmaltreated participants. Risk behaviors were also elevated among CSA survivors, including higher rates of substance use problems (t [1451] = 4.07, $p < .001$), criminal activity (t [1340] = 4.27, $p < .001$), and risky sexual behavior (t [893] = 4.42, $p < .001$) than among nonmaltreated participants.

CSA self-definition status

Planned contrast tests evaluated the hypothesis that the concordant CSA group would endorse the highest rates of psychopathology, poorest self-system functioning, and most risk behaviors, the discordant CSA group would report moderate problems in these areas, and the nonmaltreated comparison group would report the fewest difficulties in all domains. As depicted in Figure 1, this hypothesis was supported in the domains of psychopathology (i.e., subjective distress, t [1354] = 8.53, $p < .001$; emotion dysregulation, t [1447] = 6.58, $p < .001$, and anger, t [1446] = 5.05, $p < .001$) and risk behaviors (i.e., substance use, t [1450] = 4.60, $p < .001$; criminal activity, t [1372] = 4.07, $p < .001$; and risky sexual behavior, t [892] = 4.67, $p < .001$). However, this pattern was reversed in the domain of self-system functioning such that, compared to concordant CSA survivors, discordant CSA survivors showed significantly larger decrements in self-concept (t [1430] = −2.86, $p < .01$), marginally larger decrements in

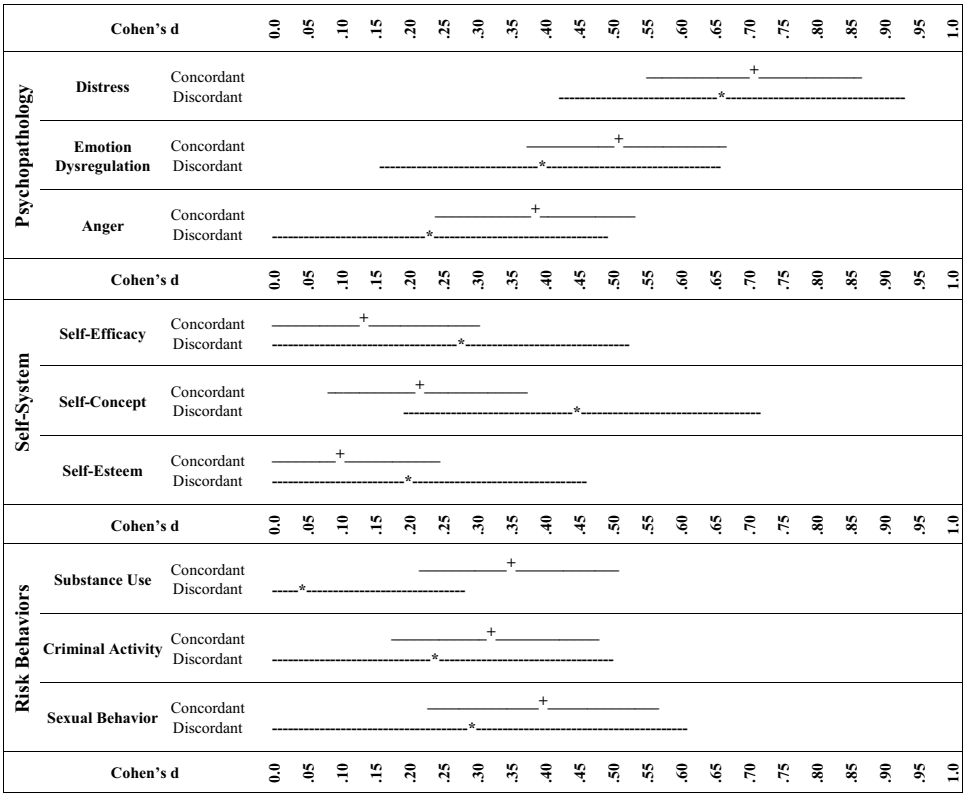

Figure 1. Effect Sizes (d; Cohen, 1988) and 95% Confidence Intervals Corresponding to T-Tests between Concordant and Nonmaltreatment Groups and Discordant and Nonmaltreatment Groups.

self-efficacy (t [1441] = −1.91, p = .06), and no significant difference in self-esteem (t [1311] = −1.22, *ns*).

Discussion

This investigation offers new evidence that survivors' self-definition of their objective CSA experiences as constituting abuse or not is related to their adjustment outcomes during young adulthood. CSA emerged as a prominent concern in this college sample with 16.6% of the respondents reporting unwanted sexual experiences in childhood and 11.5% endorsing a history of CSA by a perpetrator who was 5 or more years older than the victim. This rate is consistent with Cicchetti and Valentino (2006) CSA prevalence estimate of 10%, though somewhat lower than studies that include broader definitions of non-contact CSA (Briere, 1992). As expected, females endorsed higher rates of CSA than males (Finkelhor et al., 2015; Stoltenborgh et al., 2011). However, CSA experiences of male and female survivors did not differ significantly with regard to perpetrator identity, age of onset, use of physical force, and rates of penetration. Across ethnic-racial groups, CSA

reports were significantly lower among Asian respondents. However, the characteristics of reported CSA experiences were largely consistent across ethnic-racial groups, except that Latinx participants were more likely to identify an intrafamilial perpetrator than were other ethnic-racial groups. Although the majority of CSA survivors self-defined their experiences as abusive (76.6% concordant), a sizable minority did not (23.4% discordant). There were no gender or ethnic-racial differences in concordant versus discordant perceptions of CSA.

The size of the discordant CSA group in this study is consistent with prior evidence that up to one-third of adults fail to report substantiated child abuse (Hardt & Rutter, 2004), as well as with prior research indicating that rates of researcher-defined abuse are higher than rates of self-defined abuse (Holmes, 2008; Silvern et al., 2000; Stander et al., 2002). These rates are especially striking given that our participants were asked to self-define their experiences *after* they completed behaviorally specific questions about childhood sexual events, which likely yielded a conservative estimate of discordant perceptions of CSA in the current sample.

The phenomenology of CSA reported in the concordant and discordant groups was largely comparable, except that the age of CSA onset was older in the discordant group. Accepting personal responsibility for CSA and minimizing the perpetrator's culpability may be a more tenable coping mechanism when the age of onset is older (i.e., after 6-years-old in this study), as compared to abuse that begins at a younger age. The consistency of CSA characteristics across the concordant and discordant groups counters prior work, which suggests that self-defined CSA status is related to greater frequency, use of force, and intrafamilial perpetration (Silvern et al., 2000; Stander et al., 2002). These findings suggest that CSA self-definition may be influenced more by survivor characteristics (including chronological age) than by specific features of the CSA experience. This explanation is consistent with other data suggesting that abuse perceptions may change across development (Goldsmith et al., 2009).

As expected, CSA was associated with enduring and negative psychosocial outcomes across the core domains of psychopathology, self-system functioning, and risk behaviors. Relative to their nonmaltreated peers, CSA survivors endorsed more subjective distress, emotion dysregulation, and reactive anger, lower levels of self-efficacy, self-concept, and self-esteem, and higher rates of substance use, criminal activity, and risky sexual behavior. These findings support prior evidence that CSA is a broad risk factor for maladaptation (Hillberg et al., 2011). However, effect size estimates demonstrated that the form and magnitude of adjustment difficulties associated with CSA varied meaningfully as a function of survivors' self-definition status. Specifically, concordant CSA survivors evidenced the largest elevations in psychopathology and risk behaviors, whereas discordant CSA survivors evidenced the largest deficits in self-system functioning. Given that the characteristics of CSA

experiences were comparable across self-definition groups, this effect size shift suggests survivors' perceptions of CSA, rather than features of the CSA experiences themselves, likely accounted for adjustment differences, which is consistent with recent evidence that the costs of CSA may vary as a function of self-definition status (Vaillancourt-Morel et al., 2016).

Strengths & limitations

The current study extended the literature on CSA and its effects by examining CSA experiences in a large and ethnically and racially diverse sample as related to multiple dimensions of functioning in young adulthood, including psychopathology, self-system functioning, and risk behavior, while considering the role of survivors' abuse perceptions on these relations. Importantly, our analysis of effect sizes advanced beyond studies documenting group differences, to clarify the magnitude and direction of such differences (see Teicher et al., 2006 for example). Despite the unique contribution of this study to our understanding of how CSA effects may vary in quantity or quality as a function of survivors' self-definition status, several limitations must be considered when evaluating these findings.

First, our use of an ethnically and racially diverse, nonclinical college population supported a large sample with wide variability in CSA experiences, but may have positively biased the observed range of adaptation thereby limiting the generalizability of the obtained findings. Psychology undergraduates may comprise a higher functioning sample of CSA survivors relative to the general population, and, by extension, may have included different rates of concordant or discordant abuse perceptions than might be seen in community or clinical settings. Second, we did not assess participants' current or prior experiences with mental health treatment. Engaging in therapeutic services to process experiences of CSA may impact how survivors' view and self-define their experiences. Third, the cross-sectional design of the current study precluded our evaluation of causal CSA effects. Likewise, our reliance on retrospective maltreatment reporting introduced a number of potential measurement biases (Widom & Morris, 1997). Despite these limitations, this study employed a behaviorally specific and well-validated measure of CSA that minimized subjectivity on the part of respondents. Moreover, evidence suggests that false-positive abuse endorsements are far less frequent than false-negative abuse denials wherein persons fail to report abuse that actually occurred (Hardt & Rutter, 2004). Thus, the current findings likely underestimated the negative consequences of CSA. Although the overlapping effect size confidence intervals warrant cautious interpretation of these data, the consistency of the effect size shifts across all three indicators within each of the three domains suggests that future research and practice efforts should

examine survivors' self-definition status and meaning-making as potentially important influences on the developmental sequelae of CSA.

Empirical & clinical implications

These data suggest that, among CSA survivors who self-define their experiences as abuse, negative effects in the domains of psychopathology and risk behaviors may be especially pronounced, whereas deleterious effects on self-system processes, such as self-concept, may be especially pronounced among CSA survivors who do not self-define their experiences as abuse. Greater consideration should be given to how survivors perceive their CSA experience because this interpretive lens may help explain the specificity of pathological pathways in the wake of CSA (Tyler, 2002). Consistent with broader notions of developmental pathways (Sroufe, 1989), variability in CSA outcomes may be better understood in an agentic developmental framework that recognizes the individual's active role in coping with adversity (Yates et al., 2011). This study advances beyond prior evidence that CSA is a broad risk factor for later maladaptation, toward efforts to identify factors, such as abuse perceptions, that confer specificity on such pathways. Despite evidence that people cope and make sense of their CSA experiences in different ways, it is important to emphasize that there does not seem to be one "good" or "better" resolution to CSA. To acknowledge CSA as abuse renders the survivor vulnerable to increased psychopathology and risk behavior, yet to deny the abusive nature of these experiences may exact a toll on the survivor's self-representation.

Conclusion

The current study highlights potential problems in the broader CSA literature. Studies may underestimate the negative effects of CSA if they fail to examine more than one adaptive domain. A single CSA screening item may yield a significant number of false negatives given that nearly 25% of objective CSA survivors in this sample would have been erroneously classified as non-maltreated in response to a single item query about whether or not they had experienced CSA. This latter point has particular relevance for contemporary screening measures to assess adverse childhood events (e.g., the Pediatric ACE and Other Determinants of Health questionnaire; Koita et al., 2018). Researchers and practitioners must employ multifaceted and behaviorally specific questionnaires to accurately assess maltreatment history. Questions about meaning-making and self-definition status may point to specific areas of vulnerability and complementary areas for therapeutic attention as we help survivors to understand potential trade-offs they encounter in their struggle to cope with CSA.

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Ethical Standards and Informed Consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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