RELIGIOSITY: DOES IT ATTENUATE OR EXACERBATE THE RELATIONSHIP BETWEEN PAST CHILDHOOD SEXUAL ABUSE AND DEPRESSION, ANXIETY, AND STRESS?

by

Karmen LaShawn Payne

Liberty University

A Dissertation Presented in Partial Fulfillment

Of the Requirements for the Degree

Doctor of Education

School of Behavioral Sciences

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ABSTRACT

Individuals who experience childhood sexual abuse (CSA) suffer a global injury. In addition to the impact sexual abuse has on their mental, emotional, sexual, and physical well-being, victims of CSA also experience spiritual pain. The sequelae of pain that follow CSA may lead nonbelievers and Christians to approach churches for desperately needed help. Churches may influence the experience of those seeking help. However, the degree to which ministries are helpful is conditional on their knowledge of and preparation for working with adult victims of past CSA. Past negative sexual experiences may also harm self-cognitions, potentially influencing survivors' ability to approach God, church, or other people, further complicating the issue. Understanding the relationship between sexual shame, CSA history, and adverse emotional outcomes is key to offering important data-driven concepts for helping these wounded individuals. The results of this study are both consistent with expectations and surprising. Religiosity was noted to have an attenuating effect on the interaction between CSA and sexual shame. Further, religiosity weakens the effect of CSA on depression and stress as well supports attenuation. However, there was no significant effect related to anxiety supporting attenuation or exacerbation. Further interaction results are discussed in detail to support clear understanding and future research.

Keywords: sexual shame, religiosity, sexual trauma, self-cognitions, women

Dedication

This dissertation is dedicated to my wide circle of people that love and know me. My mother has given up many of her desires to see me finish this goal. My children have given up the times we had plans, listened to talks they did not plan on hearing, or sacrificed in other ways. To Sara and Stephani—you answered questions, edited, and taught me about tools. To Prisicilla—you know all the things. Moreover, my Aunt Anita helped me be honest with myself, calling me out when I did not dare to follow this calling.

I would also like to dedicate this paper and the work that will follow it to the survivors of childhood sexual abuse. You are the people I fight for, pray for, and desire to see healed. May the God of peace take up your cause and guide you to healing and abundant living.

Lastly, I dedicate this work to the One who gave it to me. 2 Corinthians 10:3–5 instructs us on what we are to do about our thought life. Every thought should be screened, and a decision made regarding its origin. Is the thought contrary to God's will, His purpose, His Word? If so, that thought is to be rejected! I spent many years just allowing my emotions, random arrows in the form of thoughts and other dangerous folly, to lead me around. This work is an act of worship. I have dedicated discipline to the will of God for me to overcome indulgence and choose my thought life. It is only to Your glory and no achievement of my own, dear Father.

Acknowledgments

First, I would like to acknowledge my dissertation committee and specifically Dr. Volk. I walked into your classroom, sir, unaware of my ability to even see this through. You stirred up the gift of God in me to understand I knew little. However, you taught me a way to learn so much through understanding research and thinking clearly. Philippians 3:13–16 instructs believers that there is a mature way to think and live. The of Jesus should pursue the goals set before us. God will reveal what should be changed along the journey. I have been forever changed for the better by the process you and Liberty have allowed me to pursue by God's grace.

Finally, I would like to acknowledge the excellent educators I have met along this journey that poured into me a passion for knowledge so I can help others know more. Mrs. Vest challenged me to write well and not just rely on my natural talent as a junior college student. Highlands College challenged my discipline and excellence. And so many others. Liberty University allowed me to have my own dorm experience and live campus life for a time. I am a wealthy individual forever changed. Never am I better than when I am being stretched to His will and purpose.

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List of Abbreviations

CDC	Centers for Disease Control and Prevention
CSA	Childhood sexual abuse
DASS-21	Depression Anxiety Stress Scale-21
IRB	Institutional Review Board
KISS	Kyle Inventory of Sexual Shame
MTurk	Amazon Mechanical Turk
PTSD	Posttraumatic stress disorder
RCT	Relationship Cultural Theory
RCI-10	Religious Commitment Inventory-10
TF-CBT	Trauma-focused cognitive behavioral therapy

CHAPTER ONE: INTRODUCTION

The Centers for Disease Control and Prevention (CDC, 2020) reports that one in four girls experiences childhood sexual abuse (CSA) in the United States. According to research by the Barna Group (2017) and others (Stone, 2020), more than 50% of Christian congregants are female. These statistics indicate a need to investigate the relationship between religiosity and symptoms women experience after CSA. Some women in houses of faith may discover a place of solace and expression after suffering the trauma of CSA. Considering these factors, researchers must investigate the relationships between CSA, sexual shame, negative mental health outcomes, and personal religious practice. Data produced from this research will assist congregations and counselors in reducing possible harm, developing better support systems, and nurturing healing for adults with a history of CSA (Sharp, 2010).

Churches may find unique opportunities outside the traditional service to minister to female survivors of CSA. Although sermons, religious services, and tenets of faith may provide comfort and security through normalcy and tradition, religious institutions can specifically serve the community of survivors as well. Offering community engagement through group discussions, Bible study, and counseling may bring hurting women into the church so the church may address their significant healing needs. In their review of published research, Tailor et al. (2014) found that over 50% of women suffering CSA either left the church entirely, left their church of origin, or changed churches. Further, the women in the researchers' study reported having an overall negative view of God after CSA. A lack of robust research on religiosity and CSA calls for continued and expanded research on this relationship to inform survivors, churches, and care providers.

The effects of sexually traumatic experiences, including CSA, are not confined to physical consequences alone (Lyon, 2010, Tran et al., 2019); the subsequent struggles with shame and pessimistic self-view encompass the internal woman (Tran et al., 2019). Sexual trauma, which is intimate, personal, and individualized, results in damage and the need for healing. After such intimate suffering, survivor's perception of self, God, safety, and other close relationships can be drastically changed (Tailor et al., 2014). Faith praxis may be relevant in the healing process, but pastoral care teams must be prepared and informed to contribute to recovery effectively. To be most effective, pastoral counselors must determine how empirical evidence addresses religiousness intersecting with female survivors of CSA. Ideally, Christians pursue a positive, transformative relationship with God through Christ Jesus. However, church leaders must be aware of the obstacles preventing women from moving forward in their faith practice and healing. The greater body of research has explored faith's impact on negative self-cognition, sexual shame, and religiousness after a sexually traumatic experience. This study seeks to expand that body of research by focusing on the outcomes women report from the interaction of religion, negative outcomes, and history of CSA.

Background

CSA impacts one quarter of females in the United States, according to the CDC (2020), reporting conservative estimates. These estimates include assailants known and unknown to the victim causing significant life trauma (Russo, 2000). However, over 90% of CSA perpetrators are known to the victim (CDC, 2020). CSA has a profound, lasting impact on victims, though fully understanding the areas of impact is a growing focus of research (MacGinley et al., 2019). The CDC (2020) publication, *Preventing Child Sexual Abuse*, discusses the behavioral and mental health consequences on the lives of those experiencing CSA. The national cost of CSA

for survivor care is greater than nine billion dollars currently. In addition, the CDC (2020) estimated that adverse childhood experiences make a female two to 13 times more likely to experience lifelong revictimization, thus increasing the likelihood of poor well-being overall.

A review of data on rape victims can inform the understanding of the impact of suffering after sexual abuse, particularly regarding self-perception. In their systematic review, Hockett and Saucier (2015) found results suggesting an impact on women's perspectives about themselves after rape. The women were noted to gravitate toward self-identified categories as either survivors or victims. Some survivors overcame the trauma, while others embraced a less empowered role as permanently wounded. These reported perspectives facilitate questioning how many women may carry sexual shame, negative consequences, and experience symptoms after CSA, which may even limit their spiritual lives (Brem et al., 2018). Further, researchers question what leads one woman toward empowered thinking versus victimized thinking. There are multiple elements that may be part of sexual abuse of children that may complicate victims' self-perception. The impact of pornography use in sexual abuse or assault situations must now be considered, possibly extending the victim's experience beyond a single act (Franks, 2014). According to the United States Department of Justice (2020), pornography can be connected to CSA and sexual trauma, and the age of exposure, consent, and adult-child pornography production are considerations.

Sexuality and acts related to sexuality are not independent of how individuals perceive themselves and their experiences. Talbot et al. (2004) found a relationship between CSA and shame in their research regarding shame as a core response of CSA. Volk et al. (2016) reported a negative impact on the individual's self-assessment of shame related to sexual feelings, particularly by pornography users with a religious background. This research supports the need

to better understand sexual shame and the experiences of sexual shame related to the practice of faith, the experience of the sexually abused, and impact on self-assessment of negative outcomes. The prevalence of CSA and the rising use of internet pornography, to which children are exposed at early ages, demand a clearer understanding of the post-event experiences of victims to aid in improved treatment and services.

Internal perspectives and experiences that shape cognitive views are linked to emotional, spiritual, sexual, and physical dimensions. CSA may damage the interaction between thoughts, feelings, and behavior, reflecting a lasting impact on the person in every area of life (CDC, 2020; Dwulit & Rzymski, 2019). Dwulit and Rzymski (2019) found that cognitive processing changes can be impacted by the onset of pornographic exposure, for example. Earlier onset results in an increased negative outcome for viewers due to the developing state of the brain. Skryzpiska (2017) noted that age of exposure was associated with an increased correlation between certain religious and spiritual points of view. Sexual experiences, particularly CSA, are not detached from spiritual and cognitive pattern development. Human experiences have a holistic effect on the person, and CSA or sexual trauma is no exception (Reinert et al., 2015).

According to the CDC (2021), CSA occurs whenever a person under 18 years of age engages in sexual activity outside the confines of the law or societal norms. Specifically, CSA is sexual activity initiated by an adult with a person prior to the legal age of consent or when a person cannot comprehend giving informed consent. In the past, the label of sexual abuse may have required that physical contact occurred between two parties. Current video call formats and internet sharing relieve the parties involved in sexually coercive or manipulative relationships from the requirement of touch (Pugh & Becker, 2018). Individuals, including children not developmentally prepared for sexual scenes and conversations, may yield to behaviors they

would typically resist or avoid within these forums. Adults and underage minors often fear images they "share" being exposed to family, friends or otherwise without their consent after the fact (McGlynn et al., 2017). This type of sharing may lead to fear or coercion extenuating to sexual abuse of minors. McGlynn et al. (2017) presented multiple instances supporting the criminalization of revenge pornography and other victimizing behaviors. They also discussed the production of images taken underneath people's clothing in public and posting them on the internet, or "sextortion," as sexual abuse. Often, victims have limited to no control or even knowledge of the attacker's use of material produced from the interaction.

Culture, spirituality, and religiousness contribute to well-being, sexual development, and relationship experiences (Bryant-Davis et al., 2011). CSA occurs during the time a person is forming their ideas of normal culture, spiritual life, and practice of faith. Exposure to unhealthy cultural practices, abuse, or neglect of safety can impact their development. Developmental attitudes toward safety regarding internet access, the use of social media, and other electronic sources of exposure and abuse can factor into CSA. Experiences within this context can linger with women far beyond the immediate act of CSA. After CSA, the survivor may question their safety on social media or fear the threat of exposure or extortion by images obtained previously, even in childhood or early adolescence. Electronic storage of sexual material removes the expiration date of possible exposure or embarrassment. McGlynn et al. (2017) endeavored in their work to classify sexual offenses women may face into a "hierarchy," which could now include previous child victims. This staging of experiences may allow for the identification of the level of terror a woman experiences at the hand of an abuser, an attacker, or even a former consensual partner. Relived sexual abuse experiences can bring to the surface shame and other painful experiences of the soul and spirit long after physical violence ends (Tran et al., 2019).

Abusive events may compel an individual to turn to the church for assistance. A person healing from CSA who has unsolicited contact with their attacker or images of the abuse surfacing could be revictimized (CDC, 2020; McGlynn et al., 2017). Family interactions around holidays or special events trigger old pain and the abused person's associated mental, emotional, and behavioral consequences (CDC, 2020). Stout-Miller et al. (1997) found that at one extreme, the social isolation associated with fundamentalism placed children at risk for sexual abuse from family. On the other hand, the researchers noted religious beliefs and values incorporated into the home decreased the risk of sexual abuse. These researchers concluded religion is an important factor to consider in assessing the individual and her associated needs as related to CSA overall. Therefore, churches must consider bringing empirical knowledge of sexually traumatic experiences to the forefront to equip staff and lay ministers to aid healing and prevent additional harm.

The expectations of one's spiritual community and one's personal life cannot be separated in many cultures and faith practices. Luquis et al. (2012) described the intersection of sexual attitudes and religiousness. Their findings suggested a link between a person's likelihood to engage in promiscuity and their reported spiritual experiences. This article reported higher permissive sexual behavior from male students than female students. On the other hand, females had higher scores on daily spirituality and were more open to disclosing their spirituality. These measures provide a window of observation into the students' cognitions about communion, birth control, spirituality, and intimate details of their sexual lives. This article expands upon a body of research regarding women's perceptions of God. The data produced by this research provide an extensive understanding of religiousness, sexuality, and the motivation driving behavioral choices. Training and engagement with the religious community actively assisted these students

in making life choices more in line with their beliefs (Luquis et al., 2012). These choices included pursuing a relationship with God, attending church, and making more conservative dating or sexual choices. The findings also revealed that African Americans relied more heavily on spirituality than White participants. Reinert et al. (2015) reported data suggesting cultural support and norms established by faith and community leaders set higher standards for behavior. These studies' descriptive data provided an excellent foundation for building future research and informing spiritual support in developing trauma-informed care and understanding how religious beliefs impact the lives of individuals struggling with sexual shame.

Problem Statement

The church should serve as a haven of hope and healing for survivors of CSA as healing from negative mental and emotional symptoms, and sexual shame can be pursued holistically. To achieve this ideal, researchers must analyze the relationships and interactions between religiosity, sexual shame, and negative mental health symptoms for those survivors of CSA to inform pastoral care development and leadership. Studies exist regarding aspects of religion, sexual shame and past CSA from various perspectives (Skrzypiska, 2017). Shame regarding pornography use and sexual self-esteem are well-researched related topics in literature. However, a limited number of studies address the impact of past CSA that leads to sexual shame for women. Fewer still, address how sexual shame evolves into negative mental health outcomes that can impact a woman's practice of religious faith (Razmgah et al., 2016). Reinert et al. (2015) published data describing a positive relationship between religiousness, mental health, and supportive relationships. These results suggest religiousness may be beneficial to women recovering from sexual trauma. More research is needed to ensure the well-being of CSA survivors in religious practice.

Siemens (2015) argued that sexual shame has roots in traditional religion. There is a need to research how religion impacts women facing symptoms of sexual shame after CSA (Ahrens et al., 2010). Spiritual care may become a part of the journey of healing for those suffering from past sexually traumatic experiences. However, if religious practices cause sexual shame as indicated by Siemens (2015), a closer look at how victims are supported is needed. Bryant-Davis et al. (2011) introduced to the literature the perspective of religiousness, cultural nuances, and the impact of these factors after sexual trauma, both long and short term.

Further study is needed to understand the impact of religiousness for women who have suffered sexual abuse in the past. For example, there is a lack of research targeting understanding the relationships between past CSA and sexual shame that may progress to a woman's negative acceptance of herself, relationship with God, and relationships with other women. These errors in thinking and self-perception can be obstacles that limit a woman from sharing and connecting with her religious community, which could cause a woman multiple levels of loss. The woman can lose her self-esteem and relationships at the church as a result of CSA. Also, these feelings of shame may limit her ability to connect to God as she isolates away from spiritual support. The woman hides from God and human relationships after identifying the feeling of sexual shame. The empirical evidence supports the relationship between past sexually traumatic experiences and sexual shame. There is a need to explore further how this relationship between CSA and sexual shame might be altered (Vidal & Petrak, 2007). Further research could begin to determine more effective means of decreasing the destructive power of sexual shame in the lives of individuals. Finally, an opportunity exists to determine whether these relationships result in attenuation of shame or exacerbate the symptoms during recovery for women.

Purpose Statement

This study examines the relationship between a history of CSA and depression, anxiety, and stress in adult women. Further, the study seeks to determine how religiosity strengthens or weakens these symptoms of depression, anxiety, and stress women experience after CSA. Third, this study seeks to determine the impact of sexual shame on the relationship between CSA history and mental health outcomes, depression, anxiety, and stress as a mediator. Finally, the research seeks to determine the impact of religiosity on the causal sequence of CSA-sexual shame-negative mental health outcomes as measured by depression, anxiety, and stress symptoms.

Significance of the Study

The research advances the understanding of how CSA may be related to negative mental health outcomes such as depression, anxiety, and stress symptoms. Also, the results broaden understanding of how CSA, which possibly results in sexual shame, impacts women and how religious practices may influence the relationship between those experiences and cascading mental health issues. Collected data inform researchers regarding the impact women self-report when self-appraising symptoms and experiences of sexual shame after CSA occurs. This critical information may assist other researchers in improving the use of religious or spiritual interventions to support healing and recovery, as evidenced in other work (K. Kim, 2017). In addition, researchers may become more familiar with current trends in reported childhood sexual abuse for women. Finally, light may be cast on the darker emotional experiences attached to CSA, including depression, anxiety, stress, and sexual shame. Knowledge of the challenges women face after CSA offers religious communities a unique opportunity to make a difference with data-driven approaches for supportive spiritual care.

Research Questions

RQ1: Is there a relationship between dichotomous CSA and depression, anxiety, and stress?

RQ2: Does religiosity, as measured by the RCI-10 (Worthington et al., 2003), moderate the relationship between the history of childhood sexual abuse and negative mental health?

RQ3: Does sexual shame, as measured by the KISS (Kyle, 2013), mediate the relationship between the history of CSA and depression, anxiety, and stress as reflected in DASS-21 (Crandell & Chambless, 1986) scores?

RQ4: Does religiosity measured using the RCI-10 (Worthington et al., 2003) significantly moderate the history of CSA-sexual shame-mental health outcomes causal sequence?

Definition of Terms

For this research, the following terms are understood and defined as follows:

Child sexual abuse is defined as a dichotomous self-identified experience of sexual abuse prior to 18, when the individual was unable to give informed consent or understand consent developmentally.

Negative cognitions or mental health outcomes are determined using depression, anxiety, and stress symptoms. These symptoms are measured by the Depression Anxiety Stress Scale-21 (DASS-21; Osman et al., 2012). The DASS-21 is a measure of self-reported depression, anxiety, and stress symptoms with seven identifiers of each symptom and scales measuring to what degree an individual is experiencing the symptom (Henry & Crawford, 2005).

Religiousness defined for this research is informed from the perspective of the Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003). The scores of the RCI-10 reflect

the commitment of the religious practitioner based on 10 questions. Questions address, for example, how committed one is to giving, attendance at services, and the degree to which religious views impact one's daily life. The responses given on a 5-point Likert scale (Worthington et al., 2003).

Sexual shame is defined as noted in the publication by Kyle (2013) as emotions identified through a deep awareness of perceiving oneself as "inherently flawed" in regard to one's sexual thoughts, actions, or experiences.

Summary

The subject of CSA and possible residual effects following victims into adulthood prompts the interest of this study. This study explores the questions of whether CSA leads to mental health concerns in adulthood and whether religiosity and sexual shame impact how these mental health outcomes are experienced. Research and participant responses offer an opportunity to understand better how individual women report and experience symptoms as adults after CSA. This study aims to understand the relationship between CSA and negative outcomes and how religiosity and sexual shame affect those variables.

CHAPTER TWO: LITERATURE REVIEW

The research regarding the outcome of CSA is robust. However, the research specific to the relationships between CSA, religiosity, and the negative outcomes of CSA in the lives of women offers opportunities for expansion. For decades, researchers have followed and supported trends regarding CSA and depression, anxiety, stress, and sexual shame symptoms. Religiosity and spirituality for traumatized individuals, including CSA survivors, are now a greater focus. This literature review will focus on data regarding CSA, religiosity, and women after sexual trauma of CSA. The topics of depression, anxiety, and stress in women with a history of CSA and sexual shame will be reviewed to lay a framework for greater understanding of the state of religious women with CSA in their past. Finally, this review will include literature addressing changes and trends surrounding CSA, negative outcomes, and religious practice concerning sexual abuse.

Theoretical Framework

The incidence of CSA is a worldwide issue of concern. Oz (2010) presented data suggesting CSA should be considered a specialty area of treatment for mental health providers. Mental health outcomes due to the pervasive nature of suffering by survivors call for more research and understanding of the impact of CSA on victims. MacGinley et al. (2019) discussed CSA leading to physical, mental, and emotional health issues for adult survivors long after abuse incidents conclude. Many victims report being abused on more than one occasion in childhood (Stout-Miller et al., 1997). The occurrences of CSA may extend to more significant pain. According to MacGinley et al. (2019), CSA lends to the development of shame that creates other consequences in a survivor's life. Currently, family or known assailant abuse is not the only concern of those combating CSA. Selvius et al. (2018) presented data collected in several studies

worldwide that compared children abused commercially in sex work to children abused in families. Participants in the study included mostly children under 18 years of age. The researchers found that the data on the consequences of both commercial and familial abuse lack validity. There is data from short-term reporting regarding abuse incidence, but there is a lack of long-term data collection following CSA. The long-term consequences that this and other studies bring to the surface have a lasting impact on individuals entering recovery. The article by Selvius et al. (2018) suggests that the financial burden of a longitudinal study could impede the investigation of long-term impact.

Selvius et al. (2018) found increased mental, sexual, and physical health needs for those in commercial sex work. The sexually transmitted diseases noted in those with intrafamilial abuse backgrounds are also a significant factor. Weatherred (2015) noted the overwhelming cost of care for CSA survivors, stating that the lasting effect on well-being outweighs the expenses of providing care. Weatherred (2015) considers CSA a public health concern in the United States due to the cost of care factor. These factors, considered in the light of the absence of data, leave many opportunities to expand research and discover more about the needs of survivors. More research is needed focused on understanding long-term consequences. These data could inform care and yield hope for survivors.

Oz (2010) described the adverse outcomes survivors of CSA live with daily: anxiety, broken relationships, substance abuse, and depression. In addition, these subjects displayed difficulty with acceptable behavior in school or work environments. These outcomes impact quality of life and productivity in community living. Because of the impact of these symptoms, Oz (2010) discussed making a proficiency system for experts to earn credentials in CSA treatment and described the vast need in communities to get assistance to those with a history of

CSA. Assistance should be available whether the victim is a child or adult survivor, and emphasis must be placed on the need for expert treatment, not on the age of the victim (Oz, 2010). The research indicates that understanding the mental health repercussions of CSA in the community may help churches and professionals develop skills to treat and assist survivors in the local community more readily.

The literature reveals multiple areas in which CSA impacts the lives of adults in the community. Sexual shame is a factor, for example, that Murray et al. (2007) reported negatively impacts religious attitudes and sexuality. Murray et al. (2007) found that shame and religiosity can directly impact the sexual behavior of individuals. In turn, these individuals' sexual behavior affects others due to the partnership nature of sexuality and could impact a larger community or even the church through member suffering. Stout-Miller et al. (1997) discussed the interaction between religiosity and CSA. The findings reported in this study indicated a stronger relationship between religious practice and a specific denominational attachment. These researchers reported more victims of CSA in homes with at least one or both biological parents present. This study revealed more CSA in females than males and more Caucasian than non-white victims. Interestingly, this dichotomous study using self-report measures found six common indicators for CSA: gender, mother's education background, family social status, family income, involvement with one's church, and church denomination (Stout-Miller et al., 1997). CSA is experienced in specific manners among cultures as well. Selvius et al. (2018) found that survivors' CSA experience could differ between Euro-American participants and people reporting CSA in Nepal or Mexico. In different cultures, CSA may be reported, kept secret, or accepted as a norm. These cultural differences require further study to determine factors and interactions that may influence the experiences of adults after the act of CSA ends.

Related Literature

Child Sexual Abuse

Different agencies, researchers, and groups have defined CSA. CSA may have upper age limits from 15 to 17 years (Mathews & Collin-Vezina, 2019). Activities within abuse may include sexual touching, intercourse, or oral sexual contact in a variety of ways. Children may experience abuse via an adult or another child with responsibility for or oversight of the child (Mathews & Collin-Vezina, 2019). CSA has a long-reaching impact on adulthood (Shchupak, 2015). Rind et al. (1998) defined abuse as sexual contact that places a child in coercion, including pornography, sexual exposure, and chemical exposure. Individuals may engage in sexual acts by consent that they later realize were through coercion when they were too young or unable to consent fully (Pugh & Becker, 2018). Sexual exploitation may occur during early childhood or vulnerable adolescence when some ability to provide consent is present without a full understanding of the consequences (Pugh & Becker, 2018).

Cutajar et al. (2010) reported that 5%–10% of children suffer from CSA. The same study stated that many of these victims do not report their abuse until adulthood. Cutajar et al. (2010) further provided descriptive data regarding the experiences of these abused children in their adult lives. Research regarding CSA will assist those studying CSA to understand the experiences of the abused. Further, the data collected in research studies may provide information to assist others in healing and prevent future abuse. Kenny et al. (2020) focused on the importance of exploitation research to reduce future abuse of young women and girls. By addressing the impact of exploitation, researchers may hope to understand the issues faced by the exploited, preventing a sequela of events downward spiraling the lives of the victimized. Kenny et al. (2020) concluded that multiple traumas in the lives of exploited individuals set them up for a lifetime of

adverse outcomes. The study reports that individuals may not perceive abuse as occurring depending on their perpetrator's manipulation and influence over the individual.

The coercion, control, and manipulation involved in CSA may cause an individual to wrongly perceive her experience (Kenny et al., 2020). One aim of the research is the development of tools to assess the impact of abuse and experiences on study participants to improve assessment, treatment, and understanding. The researcher must endeavor to collect data on sexual trauma and associated feelings with minimal discomfort for the participant. Researchers do not design studies to extend victims' pain; instead, detailed questions should support and reassure the victim when sharing her story of pain and the associated feelings. The development of assessment tools for individuals informs both clinical treatment and the body of research. Kyle (2013) specifically aimed to identify the feelings of shame and the underlying sexual experiences that lead to shame for individuals.

Baugher et al. (2010) addressed the individual's pain when society accepts aggression toward women as usual. Baugher's (2010) study reports that society can further exacerbate shame by normalizing the crime. Kenny et al. (2020) discussed an exploited person's pain when the love they perceive they are receiving becomes exposed as manipulation and control. These types of crimes can leave women with limited support but provide an opportunity for churches and counselors to meet needs for relationships and direction. The experience of CSA or other sexual assault must not be minimized or disbelieved. The prominence of coercion or manipulation demands researchers to take care to hear the survivor's story without judging the survivor or extending the injury.

Gender Differences in Perceptions about Sexuality

Gender is a specific variable of interest in sexual trauma research, particularly differences in how genders perceive sexuality. Data produced by gender differences studies could prompt further research on and understanding of managing the care of victims of sexual trauma. G. S. Kim and Uddin (2020) noted findings indicating differences in the physical brain and even markers in the blood between men and women. Research has reported that some of these differences make women more likely to be diagnosed with posttraumatic stress disorder (PTSD; G. S. Kim & Uddin, 2020). Structural and functional differences in the brain may hold keys to how individuals think and perceive threats (Ahrens et al., 2010; Badour et al., 2020). These articles address how the brain stores, processes, and utilizes information after a traumatic event and when future threats arise. The brain responds differently based on gender (Blain et al., 2011). Blain et al. (2011) studied 112 women with a history of single to complex trauma; the findings indicated a correlation between sexual self-schema and a negative impact on the victim's perception of self, the world, and others. Also, the data indicate that only changes in cognitions stood alone as a variable directly connected to the sexual schema. The disparities in the functions and processes of managing recovery from trauma may lead women to struggle more than men with chronic recovery needs. Ng et al. (2018) suggested that suicide attempts and poor mental health functions stem from early sexual trauma. More women than men suffer these early-life sexually traumatic events and thus may suffer more suicidal ideation as a result. How the body responds to traumatic events is also notably different between the two sexes. Therefore, researchers must continue to gather data to understand how biology drives women's various responses to the trauma faced in their lifetimes. Additional data regarding the impact of trauma,

including CSA, may expand or improve interventions and outcomes for women, their families, and the communities in which they live.

Baughter et al. (2010) reported data regarding myths or social beliefs regarding the sexual traumatization of women. For example, some may believe that women operating outside traditional roles may provoke sexually traumatic events, while others may even see aggression as typical toward women in certain cultures. Therefore, focusing on how sexual trauma impacts women's thoughts, faith, and experiences may allow future researchers to understand and assist survivors. Dhuffar and Griffiths (2014) identified how shame and hypersexual behavior might be related. The researchers reported a significant intersection between shame and negative consequences of sexual behavior.

Furthermore Dhuffar and Griffiths (2014) report, the experience of shame is significantly affected by age—senior generations are more prone to shame than younger ones—and specific sexual behavior produces more shame. Results Dhuffar and Griffiths (2014) reported did not support religion as a significant influencer of hypersexual behavior, as it impacts the level of shame. The reported results suggest that anonymity of the preferred sexual behavior of women may alleviate shame. There is a significant need to understand sexuality and sexual shame for the female gender. Research regarding a significant event, like CSA, may reveal an improved overall sense of well-being, faith experience, and recovery from the traumatic event (Ahrens et al., 2010).

The impact of sexual trauma such as CSA may place limitations on women's psychological well-being and interactions following the sexual trauma (Breitenbecher, 2006). Breitenbecher (2006) reported that women have an increased sense of disturbance when assessing internal character flaws contributing to their assault history and long-term adverse

outcomes. The experience of evaluating oneself as weak or inferior impacts the woman's perceptions of self and the world around her. Specifically, Breitenbecher (2006) reported women feeling more distressed from how their survey answers reflect on their character than tension placed on measuring their behavior. This distress may cause them to misassign blame or risk future assault situations. Empirically supported interventions can positively shape the understanding of why this distress occurs and how to help women after trauma.

The pain and dysfunction of sexual trauma may impact a woman in various areas of her life (Overbeek et al., 2018, Reinert et al., 2015; Tran et al., 2019). Zvara et al. (2017) investigated outcomes in the lives of mothers who were sexually abused as children. The results indicate heightened harshness and intrusiveness in parenting for mothers with a history of CSA. The mothers were more prone to manipulate, seemed unaware of their child's feelings and thoughts, and were ignorant of the impact of their experience with CSA. These women are left unhealthy and therefore negatively impacted in their ability to employ healthy parenting skills with their children. The negative impact spreads beyond the abused individual and into her offspring as her behavior is modeled for her children. Zvara et al. (2017) provided data to show how sexual trauma may leave a woman bereft of energy for parenting and even lead to her perpetrating physical abuse. Further, Deitz et al. (2015) reported that self-stigma increases the negative in-home experience and may lead to family breakdown or ongoing cycles of abuse. Women who making decisions and experience life with a negative thought pattern cannot provide a healthy, positive, nurturing environment. These findings highlight the urgency to understand women's cognitions in response to sexual events of a traumatic nature.

The Role of Spiritual Support

Counseling interventions and treatment modalities alone are not sufficient to meet the needs of women after sexual trauma. Women need spiritual support, mentorship, and the warmth of a supportive community; a religious community can provide such relationships and wisdom from more mature women with similar experiences as a low-cost, efficient support method. Delker et al. (2020) reported the benefit of assault victims-turned-survivors sharing their redemption stories. Churches may be an excellent setting for women to share in groups built on mutual belief. Churches should not replace counseling or group treatment. However, as an adjunct, the religious community may offer many other supports, such as children's learning environments that support a parent in need of childcare during groups.

Sexual Shame

According to Kyle (2013), shame leads to the gauging of the individual's performance or decorum in behavior through a critical lens of the person's value. Prosek et al. (2017) simplified the subject by setting shame apart from guilt. Prosek et al. (2017) described guilt as a fault in behavior, while shame is described as finding fault within oneself. Shame has been associated with sexual and violent trauma (Aakvaag et al., 2016). Specifically, sexual shame is rooted in the experience of sexual behavior, focus, or activity, particularly when nonconsensual or outside norms (Kyle, 2013). The sexual nature of human beings is at odds with the experience of sexual shame related to sexual behavior.

There is an internal comparison between what individuals desire, what society or culture brands acceptable, and what the person does behind closed doors (consensually or without consent). This comparison, when steeped in negative self-perception, yields shame from guilt. Murray et al. (2007) addressed the nature of sexual shame as attached to an individual's core

identity. The research suggests that shame and guilt impact the individual's relationship with God negatively. However, though a person experiences shame and guilt for sexual practices, the sexual practices do not end due to the experience of shame. Pinto-Gouveia and Matos (2011) described shame as an "outstanding" emotion not primary to those intended to be in the human experience. The feeling of shame is not one among many in a sea of emotions experienced normally throughout a week or a day. Instead, shame is connected to an assessment of self (Kyle, 2013). And, the consequences of shame repeatedly rear their heads at various points in an individual's life. Shame can impact mental health, personal relationships, one's perception of God and humans, and more (DeCou et al., 2017). Sexual shame can be an experience imposed on an individual or brought on by the individual's addictions, compulsions, or chosen sexual activities. The sources of sexual shame in society are myriad in an image-soaked media titillating with sexuality (Samson & Grabe, 2012). Murray et al. (2007) presented specific data regarding the social, cultural, and spiritual impact of shame related to sexuality (including pornography), chemical addiction, and sexual behavior that may develop into a tangled experience. This combination of factors may yield an increased shame experience in the lives of individuals and drive them to the place of seeking help to heal through psychotherapeutic interventions or other means (Pinto-Gouveia & Matos, 2011). Grubbs et al. (2013) developed a tool to assist researchers and clinicians in assessing pornography users' perceived addiction and the distress this perception causes. The measure demonstrates a causal relationship between sexual self-perception and distress in the individual's resulting experience.

Shame or fear of the consequences of shame may be of benefit to society to a degree (Dhuffar & Griffiths, 2014). For example, certain researchers submit that benefits from sexual mores due to religious taboos that limit sexual assault, rape, and child abuse must be considered.

Sheikh and Janoff-Bulman (2010) added to the body of data the proscriptive nature of shame, which deters some behavior in society. This proscriptive motivation focuses on behavior that one must abstain from doing. This is important in considering sexual shame. Sexuality is not at its core condemned as shameful. However, certain internal motives or desires that initiate sexual expression may be outside of expected or accepted norms. For example, pedophilia or violent, pornographic images are not viewed as socially normal. However, the expression of other focused lovemaking in marriage is an accepted norm within societal standards (Siemens, 2015). Murray et al. (2007) conducted a study on the interaction of spiritual practice, emotional state, and physical experience. The researchers' examination supports a connection between spirituality, feelings, and sexual practices associated with religious activity (Murray et al., 2007). Thus, sexual behavior itself does not produce shame.

Delker et al. (2020) examined the societal pressure on victims of sexual trauma to keep silent versus the telling redemptive stories and overcoming the trauma. This voice restriction keeps victims immobile and unable to free themselves from the shame and limitations the past event places upon them. Victims need to move beyond the trap of event-induced shame to the place of overcoming for healing. Unfortunately, there is no one-size-fits-all approach to recovery. Some women that must talk it out, while others cannot speak of their trauma for adequate healing to occur. Kyle (2013) identified the lack of research on sexual shame due to the taboo nature of sexual topics in public forums. The religious setting may be a forum in which sexual shame survivors could share confidentially to promote healing. Additional research is needed to help fill this gap by addressing the pain of sexual shame and traumatic shame-producing incidents in religious settings in the United States.

Negative Outcomes

As researched by Karatzias et al. (2018), negative cognitions present as deprecating thoughts, ideas, or experiences that one uses to measure the self. The experience of traumatic or undesirable circumstances can repeatedly affect the thoughts of individuals. Cognitive behavioral therapy can assist women battling chronic trauma with negative cognitions. However, Karatzias et al. (2018) introduced the strategy of "targeting" specific negative cognitions that may drive the mindset and behavior of people struggling with chronic trauma. Hockett and Saucier (2015) explored the importance of women viewing themselves as survivors rather than victims after rape to combat negative cognitions. Their article reports findings to support the negative impact of powerlessness associated with victimization. Data regarding the impacts of the different ways women see themselves lend crucial information to the body of literature regarding the impact of sexual shame and victimization. Sexual experiences, whether by force or initial consent, that took an abusive turn may produce negative self-cognition. The cognitions may create responses in a woman after the event. How a woman views herself will inform how she interacts with the world around her and her belief system (Hockett & Saucier, 2015). Research supports the need to understand the impact of negative and positive support on individuals after trauma (Bjorck, 2007; Koenig et al., 2001; Littleton, 2010). Support systems that provide positive resources are necessary to assist survivors in recovery to bolster their thought lives and perceptions of themselves. Negative cognition development is not supported in the literature as a likely experience for those in healthy relationships (Littleton, 2010). Blain et al. (2011) underscored the need for more investigation into how women view themselves, the world, and others after a traumatic experience. Self-cognitions or "cognitions relevant to the private self" influence the inner perspective of individuals (Bromgard et al., 2006, p. 88). Interacting with the world and

others from this internal self may influence healing from trauma, spiritual well-being, and the relationships in a person's life. This point of view may also alter how a person sees or relates to God and practices one's faith. This may directly impact healing or reaching an altruistic state of forgiveness of self (Langman & Chung, 2013).

Negative cognitions, researchers note, often initiate as intrusive thoughts after trauma and may signal difficult or ineffective healing (Tran et al., 2019). Karatzias et al. (2018) published findings to identify the problems imposed on a person by negative cognitions resulting from traumatic events. Karatzias et al. (2018) analyzed results from interviews of 89 women that experienced both adult trauma and chronic childhood trauma prior to commission of a crime. The research indicated complex or repeated traumatic events increased the likelihood of poor behavioral choices in adulthood and increased emotional dysregulation reported by the women. This is important as it establishes support for the chronic nature of intrusive thoughts and negative cognitions, and strategies can be adapted accordingly. Self-blame, for example, may manifest in a survivor's life in a manner that requires long-term coping skills. Others may only require training during a short treatment period to overcome temporary symptoms. Accusing internal voices may imply that the victim could or should have avoided this sexual trauma through different choices. G. S. Kim and Uddin (2020) reported there must be an evolution of the perception of the event from a focus on "me" to the shared experience of pain common to all people through life. Otherwise, sexually traumatic experiences could separate individuals, and isolation presents danger (Kucharska, 2020). In isolation, support systems disintegrate. These needed support systems provide sustenance through sources such as communication with others and faith. Tran et al. (2019) revealed how negative cognitions could have an insidious impact on the individual's ability to receive support leading to lower quality of life and increased

experience of isolation (Littleton, 2010). The individual with lasting negative cognitions may easily avoid and withdraw to escape the need to address the painful emotions attached to the event. These avoidances may lead to substance abuse or other mental health concerns. Further, these negative cognitions may surface as shame or other imprisoning feelings that reinforce the walls between the individual and the help they desperately need.

Holliday et al. (2014) identified the need to discern negative cognitions to correct thinking errors. If the client is to identify negative cognitions, there must be vulnerability in therapeutic relationships. Worthington et al. (2003) reinforced the vital role religion plays in the effectiveness of counseling for clients. If an individual suffers sexual shame that leads to negative self-cognition, the individual must be honest and open and willingly share feelings and thoughts to find healing (G. S. Kim & Uddin, 2020; Weiss, 2010). If the shamed person perceives signs of rejection from professionals, clergy, or laypeople, the conversation is likely to shut down (Littleton, 2010). Even if the wounded person remains in the room, the identification, confrontation, and replacement of these negative cognitions may not achieve healing. Sensitivity and trust are principles in healing shame and negative cognitive patterns. Sharp (2010) explored the success of prayer as a means of support through discussion, with God as the other in the exchange. The data from this study provide evidence supporting the need for individuals to have another to lean on when healing from sexually traumatic experiences.

Research regarding sexual shame seeks to identify how past traumatic experiences create sexual shame and negative self-cognition, impacting women's religious practices. Current literature addresses the individual components of sexual shame, negative self-cognitions, and the benefits of religion after sexually traumatic experiences. However, there are gaps in the literature related to these processes at work in women's lives. Sachs-Ericsson et al. (2006) added data to

the body of research, regarding unhealthy cognitive schema from abuse and the possible causal relationships with negative self-cognition. The research suggested a possible relationship between abuse and development of schema that may lead to negative cognitions in the form of self-criticism . Though focused on parental verbal abuse, this study lends credibility to the likelihood of unfavorable outcomes due to past traumatic events. Further, these findings support the need for more research regarding the influences of trauma on self-cognition and the role of self-cognition in healing. Shame and negative cognitions are related (Badour et al., 2020) and are obstacles to healing. Cleare et al. (2019) provided evidentiary support for the connection between forgiving oneself and decreasing the role adverse emotional outcomes may play in the individual's healing process (Rudolfsson & Portin, 2018). Therefore, understanding the faith practices of sexually traumatized women may assist those helping survivors to find hope with evidence-based interventions in the individual's church of choice.

Sexuality and Cognitions

Sexuality, as an expression of the inner self, is affected by the woman's cognitive state. If the woman perceives herself negatively, she may also struggle to accept her sexuality. Renaud and Byers (2001) published results regarding the impact of sexual cognitions on the experiences and feelings of individuals. The reported relationships between sexuality and cognitive state may be connected to mechanisms that lead people to develop shame or guilt from their sexual thoughts or fantasies. These findings are significant, as the researchers suggested individuals appraise themselves based on their sexual cognitions. These findings lend to the body of research that shows that these negative self-appraisals may directly affect how the participants perceive themselves in social settings and their interactions with God. The impact of negative self-perceptions on early development may lead to later negative cognitions about oneself and is

potentially meaningful (Trickett et al., 2011). In addition, abuse or unwanted sexual experiences can profoundly impact these cognitive experiences and thought patterns and reinforce negative beliefs. There is an opportunity to expand research and data to support and increase the understanding of how these thoughts develop and interventions that can positively impact survivors' healing.

Sexuality and cognitive patterns also share a connection to other behavioral outcomes in research. For example, Holliday et al. (2014) measured the severity of PTSD symptom severity, depression severity and severity of PTSD cogntions for 226 female Veteran survivors of sexual trauma in the military. The research by Holliday et al. (2014) specifically aims to identify the common post sexual trauma cognitions these survivors experience. The survivors of military sexual trauma in the group (N=88) identified more strongly with self-blame cognitions than those that had not experienced military sexual trauma. This suggests a powerful link between symptoms and self-cognitions may exist. Cognitive scripts may have a different impact in other settings. While common, pornography exposure is related to sexual scripts that may impact healthy cognitive functions (Tomaszewska & Krahe, 2016). This schema or script becomes more dominant than reality. Tomaszewsak & Krahe, (2016) surveyed 524 senior high school students in a Polish city. The researchers set out to determine the influence of religiosity on pornography use and the use of pornography on risky sexual behavior and aggression for these youths. The resultant attitudes toward coercion and sexual aggression reported by youths in this study revealed a shift in behavior after pornography exposure, as the researchers reported an overall noted change in sexual aggression among young people. This increased aggression leads to an increased need to understand and mitigate these negative cognitions after events that may influence sexual scripts, cognitions, and resultant behavior. Tomaszewska and Krahe (2016)

noted a degree of impact on both males and females including higher male pornography use and higher religiosity in females. An interesting detail of this study reveals risky sexual scripting correlated positively with pornography use and condoning sexual coercion. Both Holliday et al. (2014) and Tomaszewska and Krahe (2016) shed important understanding on the need to improve treatment of impacted individuals and help construct education in a manner that will assist victims and perpetrators in the process of recovery to avoid coercive circumstances that lead to pain and suffering.

Religiousness

Hook et al. (2015) described religiousness as beliefs that imto epact values and morals used to govern daily life choices. The core fabric of the individual is influenced by their belief system, which serves as a compass for decision-making. Hook et al. (2015) reported the challenges those suffering from trauma might face due to sexual incongruence. This occurs when their choices in life do not line up with their moral standards. The results, published from collected data on 191 students suffering adverse outcomes after sexual incongruence, identified low self-forgiveness and high spiritual discomfort in these individuals. Dissonance between belief and action creates a crisis for specific people. At times, religious judgment or perceptions of God as harsh can frame religion in a negative light. Park (2007) noted a meaningful link between religiousness and spirituality in healthy life outcomes. The individual's experiences may directly impact how that person perceives religious practices.

Gostečnik et al. (2014) reported findings regarding neurobiological blockages in the traumatized brain that impact both social and survival decision-making skills. This area of research reveals the comprehensive change in how an individual perceives other people, the world, and God. Data to support healing will directly influence the religious experiences of those

seeking help and healing through connection to their church (Pinto-Gouveia & Matos, 2011). The practice of faith tenets, such as prayer, meditation, and reflection, help heal individuals facing traumatic circumstances. Sharp (2010) revealed that the individual's perception of herself impacts whether religiousness aids or impairs the injured individual as a practitioner. This study further offered findings on the relevance of religious practices, such as prayer or meditation, in assisting people in managing their emotions. Those with greater faith or a closer understanding of God have an increased positive outcome from receiving spiritual support. Conversely, a person that lacks a relationship with God may not benefit as much from spiritual or emotional support. These studies' factors and findings underscore the importance and relevance of spiritual practice in changing the lives of sexual trauma survivors. These results call for extending research studies and data collection regarding sexually traumatic experiences, shame, and self-cognitions in relationship to spiritual healing. A commitment to studying these factors offers caring professionals many empirical modalities to improve outcomes for survivors for a lifetime.

Religious practice or spiritual counsel may contribute significantly in the healing of child abuse survivor treatment and recovery. However, much of the research does not place religiousness and sexuality in a positive light. For example, Ahrold et al. (2011) reported that sexual conservatism is often directly linked to religiosity. The conservative sexual standards of these individuals influence how they experience trauma and healing. Also, sexual experiences, including cognitions and preferences, guide how people experience recovery from sexual trauma. This leads to a question about how open a woman might be in a conservative faith setting after experiencing sexual trauma like CSA. Further, if she chooses to be open about the experience of CSA, will she receive support or spiritual judgment?

K. Kim (2017) explored the experience of shame and power as they interrelate. The data from K. Kim's study point out the vital dynamic of power Christian pastoral counselors possess in soul care. Therefore, the pastoral counselor must take particular care to understand their authority and manage each client wisely. The implied position of power for the counselor and vulnerability for the client requires particular concern, prayer, and intentionality to provide excellence in caregiving. Religious institutions, tenets of faith, and religious education can impact how survivors of traumatic sexual encounters may with a pastoral counselor and their peers. The individual may assess the waters of trust within their church and share intimate knowledge slowly. After initially sharing, the woman may evaluate her trust in the confidante, church, and even God from the reaction she perceives after disclosure. Pastoral care staff must be aware of the value of the confidence of those they serve and guard it carefully. The research in this area has moved pastoral care to a new level of validity, supporting the spiritual needs of those recovering from traumatic experiences (Bowland et al., 2012). Advancing research in this area will further develop the agenda of pastoral care to help the oppressed in society by utilizing evidence-based, data-driven care (Bowland et al., 2012; Bryant-Davis et al., 2011).

Religiousness interacts with the way individuals perceive themselves, how they interact with others, and their core concept of God. Gostečnik et al. (2014) produced data suggesting that people could have mixed feelings toward God, relationships, and faith after trauma. The researchers published neurobiological, developmental, and functional data regarding religious practices that directly impacted individuals at every level after abuse. There must be a safe harbor for victims of traumatic experiences to become close and connected and work through the mangled aftermath of their thoughts when trauma occurs. According to Gostečnik et al. (2014), churches play a key role in reconnecting the wounded person to stability and a renewed sense of

security. The role these churches play could impact how survivors view spiritual life after trauma on either end of the spectrum and leads to a permanent need for caution in managing their soul care.

Skrzypiska (2017) provided a perspective on the evolution of worldview of spirituality and religiousness in this era. Worldview, spirituality, and religiousness play distinct but related roles in women's lives. Skrzypiska's (2017) results included a positive correlation between spirituality, worldview, women's belief in a higher power, and religiousness. This correlation indicated a responsibility of churches to strengthen their representation of God as safe, secure, and loving to the hurting. Chance and self-reliance are not sufficient for healing to occur. Ambivalence after sexual trauma or resulting from sexual shame does not benefit the survivor and may undermine recovery. However, aggressive support from church relationships, pastoral care, and faith communities may promote a full recovery for the individual and the people in her life.

Jaworski (2015) researched the impact of spirituality from two perspectives, which may help individuals better understand sexual trauma recovery: theocentric and anthropocentric. Jaworski (2015) reported the positive impact theocentric-connected individuals experience because of their view of God and the human spirit. Theocentric-connected people were more balanced and able to manage their emotional state. They functioned more surely during challenging seasons from a solid framework of faith. An unwavering belief in God and His Church can provide a state of emotional well-being in the face of great pain. Further, Janiszewska et al. (2008) supported this idea with findings regarding the impact of spiritual well-being in the lives of breast cancer patients facing pain and loss connected to sexuality and identity as a woman. Although there is no conclusive evidence suggesting that specific beliefs or

practices are more important than other spiritual practices on outcomes, support is given to a personal relationship with God. Janiszewska et al. (2008) further concluded that religiousness yielded a positive outcome for those coping with complex disease states such as anxiety caused by breast cancer. This is influential in research, as trauma breeds anxiety and shame. Therefore, research must determine how religious practices help the sexually traumatized recover from similar symptoms.

Rudolfsson and Portin (2018) raised questions in their study regarding the intersection of sexual trauma, shame, and religion's role in healing. This study primarily focused on adults reporting childhood or early life sexual abuse. The data lend credibility to the need to understand how churches interact with women suffering silently from shame after sexual trauma. Chan et al. (2012) ascertained that the women recruited for group prior to a traumatic experience with Gulf Coast hurricanes had an unanticipated set of positive experiences related to their intersection with the community and church after the hurricane. The results of this study revealed a positive correlation between the women's support system in society, positive outlook, and connection to a purpose outside themselves. This is of interest due to the circumstances in which Chan et al. (2012) reported findings related to women's care in natural disasters. Primarily, churches work through relationships to positively impact the lives of both members and unaffiliated individuals in the community. They highlighted several areas that may lead to the positive impact of religiousness on overall social well-being. For example, religious practitioners, defined as those connecting with social engagement and volunteer opportunities, adjust better after traumatic events as they contribute to their fellow man's recovery. Rudolfsson and Portin's (2018) study concluded that faith communities play a definite role in healing those who hold their faith in high esteem. Creating a safe space for healing is critical for every type of counseling situation. These

researchers also supported interventions that include faith, giving back, and staying connected as primary steps to recovery after traumatic events in any setting.

Koenig et al. (2001) concluded that an individual's faith practice could positively impact growth through adverse health events. The experiences of the individuals reported in the study results included a sense of powerlessness and negative feelings toward themselves due to the limitations caused by their diagnoses. Further, the researcher desired to measure data regarding the impact of self-perception and how the chronically ill view the world and learn of resources to manage their care. Finally, researchers sought to investigate the level of confidence developed over time with repeated support and freedom to make choices, good and bad. The researchers concluded that when physically or chronically ill individuals lean into their faith and community for support, they progress with more hope and control of their care. Therefore, the person is able to identify reliable resources and feels she can interact with services or ask for help more adequately (Bowland et al., 2012). Conversely, with a lack of support and few options, the clients give up or fail to initiate. Churches may become a resource beyond hosting weekly services and evolve to serve their community members directly. Religiousness is a positive influence in current research studies, challenging the boundaries separating physical and spiritual impacts from each other (Chan et al., 2011). The results suggest that the body and soul respond to the wellness of the spiritual life.

Spiritual practices play a role in the lives of individuals and may be critical after traumatic events (Knapik et al., 2010). Chan et al. (2011) pointed out opportunities for the community to help posttraumatic victims. This and similar research find that religiousness positively supports trauma victims' recovery (Deitz et al., 2015; Dorahy et al., 2012). Deguara (2019) studied the experiences of Catholics in Malta when their lives are not congruent with their

beliefs. The surveyed Catholics expressed sexual shame after divorce. All the participants that expressed shame were women, and no dishonor was expressed toward their ex-spouse. However, if the women were in a new relationship, both the women and the community perceived this as shameful. Deguara (2019) described shame as unnatural when experienced after a traumatic event like divorce. Divorce is perceived as a moral failure, and these women are seen as immoral if they engage in any other sexual relationship in the future. Therefore, according to Deguara (2019), the women live under the belief of God no longer accepting them because they are in a relationship. This type of dissonance in certain people leads to emotional distress. Therefore, specific research findings suggest that religiousness harms an individual's life when he or she violates his or her conscience. Religious practices such as prayer or meditation could be positive interactions that assist the individual in addressing and managing their feelings (Hinojosa et al., 2017; Sharp, 2010). There is ample research applicable to these separate practices; there is a deficit in the literature regarding how post-sexual trauma shame can hinder community and spiritual support due to negative cognitions. The gap may be resolved by an investigation of how religiousness is measured in each case in the literature. Hall et al. (2008) reported individual measures that reflect religiousness among the literature. For example, religiousness may be measured by church attendance, private religious engagement in the home, the driving factors behind individual decisions, or feelings about God. Outcomes may be changed by the differing definitions of religiousness.

Cognitions

Ramirez de Arellano et al. (2014) researched posttraumatic stress and the impact of symptoms following a traumatic life event. Karatzias et al. (2018) addressed negative cognitions and the tendency of symptoms to resurface until clients acquire skills to combat the reoccurring

thought processes or redirect thinking. Trauma focused-cognitive behavioral therapy (TF-CBT), as presented by Ramirez de Arellano et al. (2014), involves a strategic plan of treatment and skill acquisition to assist clients in navigating healing. Negative cognitions such as shame-based thinking, self-blame, or other self-critical thought processes can bankrupt an individual's ability to emotionally self-regulate or manage thoughts. TF-CBT equips a counselor to educate and prepare clients to identify negative cognitions or unhealthy thinking patterns and manage their thought lives effectively. Familiarizing themselves with behaviors attached to the negative thought and replacing it with other outcomes or truths gives clients a calm experience of making choices rather than re-experiencing overwhelming circumstances.

TF-CBT and its strategies differ from other theories and their related strategies and skills. Specifically, the focus of TF-CBT is individualized treatment and not group strategies. The skills training is designed for individual use and self-reinforcement. However, TF-CBT and spirituality can be connected. The client may choose a specific passage or thought for meditation or use deep breathing and relaxation techniques to overcome moments of stress. The individual can implement personal spiritual practices with this technique to use new skills more naturally in their daily lives.

Crandell and Chambless (1986) described negative cognitions as involuntary, unwanted thoughts or attitudes that cause an individual to incorrectly evaluate oneself or others as having declining value. Negative cognitions addressed in the literature are associated with various conditions, including depression, abuse, or chronic negative schema. However, little research connects spirituality or religiousness to the treatment of negative trauma-related cognitions, particularly sexual trauma.

Badour et al. (2020) reported on shame-proneness, cognitions about rape, and sexual trauma. This study is interesting as the sample was initially quite large, with 1,094 participants. The participant pool was not specifically women. The sample size was reduced to 884 through data screening from indications of individuals marking that they were both “raped” and “not raped” on different questions. This elimination is interesting and raises the question of why an individual would mark “raped” in one section and “not raped” in another on the same data set. One hundred thirty-two individuals indicated sexual trauma history, and of those, 129 participants met the criteria for inclusion in study. Researchers targeted interactions between rape myth beliefs and attitudes toward women. In this study, shame-proneness was positively correlated to self-blame, negative cognitions about the self, and the world. Interestingly, this article also addresses how the experiences of individuals influence or are influenced by cultural norms and expectations that may produce or induce shame after sexual trauma. Negative thought patterns may also result from cultural mindsets or norms women may have accepted early in life. The aim of the research by Badour et al. (2020) was to understand how gender and attitude influenced cognitions about rape or sexual trauma. The element of spirituality or religiousness was lacking completely in this study. However, culture is not devoid of spiritual beliefs about genders; in some cultures, women are treated differently simply because they are women. A culture may assume some sexual expectations and assign shame about sexuality just because a person is born male or female. The gap in the body of research could decrease through research that delves more deeply into how women feel about themselves, their femininity, other people, and God after sexually traumatic experiences. An Iranian study of the impact of social networking pages on women in short burst messaging (Razmgah et al., 2016) supported the relationship between women and culture that informs their self-cognitions. For example,

Razmgah et al. (2016) reported significant differences in women's pretests and posttests of the Cradell cognition inventory after random assignment to groups on social networking sites and exposure to accompanying short messages about themselves. Women discern the messages around them from culture, religion, and even social media. Studies regarding the effects of sexual trauma on how women feel, think, and relate can expand researchers' understanding of the damage to the human spirit and soul that occurs when the body sustains attack through sexual trauma. Blain et al. (2011) presented data results regarding the impact mechanism for negative cognitions. The 112 sexual assault survivors that participated did not exhibit PTSD. However, the women reported experiencing negative cognitions, particularly in how they viewed themselves and their sexuality. The study's results indicated that women who viewed themselves negatively tended to have more negative cognitions about the world and others. Those with positive thoughts about themselves tended to see the world positively. These findings could inform how these same women view relationships with other people and God in other settings and prompt further research on improving interventions for the lives of those in pain.

Proposed Theories for Interventions in Sexual Trauma

Various theories support the interventions and treatments available to counselors, pastors, and other human services professionals. Women facing the obstacles that follow sexual trauma need community and individual support to achieve healing and forward movement in their lives (Kress et al., 2018). This section addresses three theories that can be used when assisting women in overcoming struggles in thoughts and feelings, soul care, and support connections. Theories of treatment and intervention have been developed based on relationships identified in past studies, and the theoretical applications have opened a pathway to further research that will promote

healing. The reviewed literature finds data-supported causes and effects regarding sexually traumatic experiences.

Cognitive dissonance theory is an example of a data-driven intervention for women combating shame, adverse thinking outcomes, and spiritual distance after an intimate partner perpetrated traumatic event. Hinojosa et al. (2017) reported data that assist researchers in understanding the mechanisms of pain and suffering in a person's life when two cognitive states are at odds within an individual. For example, a deeply spiritual person who believes in purity but struggles with sexual shame due to sexual experiences may encounter dissonance. Hinojosa et al. (2017) also discussed changing one's cognitive life to reduce dissonance and promote healing. This article presented healing steps, such as establishment of boundaries, focused cognitions, and consistent decision-making. Hinojosa et al. (2017) referenced cognitive dissonance theory as best utilized when influenced by other theories to improve its efficacy. Keller and Block's (1999) study suggests two distinct types of dissonance: affect based and cognition based. Affect-based dissonance is tied to the processing of negative emotions. Cognition-based dissonance is a tug-of-war between thoughts and the truth about oneself. In all, dissonance is the inability to reconcile opposites within oneself. Sexual trauma may create a chasm between what the individual experiences and what the individual thinks, feels, or believes.

Resolving dissonance can bring about the single-minded focus of heart that clients need to overcome the pain they are suffering. Deguara (2019) published a study regarding life-reconciling dissonance for Catholics in Malta, specifically individuals that report living justified before God after moral error with happiness and no stigmatization. For example, one of the study participants reported finding happiness in a new relationship after divorce. Nonetheless, while remarrying and reconnecting with God, this participant accepted the mistake of a poor decision

related to the first marriage. Their church may or may not embrace releasing the stigma regarding the divorce, yet the participant pursued a relationship with God again. These findings may indicate reconciliation of distress as applicable to both the internal state of the client and their connection to other people and the Creator.

Relationship cultural theory (RCT) offers treatment strategies for managing clients suffering from sexual trauma or other traumatic events of an interpersonal nature. Kress et al. (2018) specifically reported research findings that support RCT as beneficial in trauma counseling. The concepts that drive RCT can benefit counselors' interventions and treatments that facilitate the ability of the individual to cope with and enjoy life. Relationships are a significant area of an individual's life and can be destroyed by interpersonal trauma. The disruption to support systems and faith in others becomes an obstacle the victim must overcome. The loss of healthy relationships in a person's life leads to the ongoing loss of support systems and stability. RCT offers processes and interventions to assist clients in overcoming the hindrances to building lasting, life-giving relationships. The benefit of intentionally constructing new relationships outweighs the person's challenges while they develop new skills and community.

Kress et al. (2018) reported that women were more likely to experience trauma than men and needed a more extensive network of support. The data establish a possible link between the likelihood of sexual assault and the disruption of intimate trust. The researchers referenced RCT as an appropriate intervention for clients suffering prolonged and repetitive sexual abuse. The article reported that RCT strongly emphasizes the importance of relationships for mental health. The common ground clients find between the cultural understanding in treatment and focus on relationships make this theory a viable option for individuals seeking to provide care to sexually

traumatized women. The researchers found that participants with healthy relationships began the process of healing from past trauma more readily. Kress et al. (2018) presented the specific steps of RCT in connection with the benefits of the intervention for healing trauma. RCT employs relationships to facilitate experiences of empathy, clarity, creativity, and connectedness in the traumatized person's life. Those without these relationships suffered less efficacious outcomes, as isolation and the loss of self-care expanded after trauma. Religious gatherings can facilitate the building of these relationships with people through the empirically informed use of intervention. The application of these interventions indicates that connectedness to both man and God can assist clients on a healing journey to renewal and hope. Kress et al. (2018) provided findings that underscore the value of religious practices, relationships, and cultural support in healing.

Bowland et al. (2012) reinforced the importance of spiritually focused interventions and relationship-building for intimate trauma recovery. This research primarily focused on women over 55 years of age. All the women reported an experience of CSA or were sexually assaulted earlier in life. This interpersonal trauma has physical and mental health manifestations that often present later in life. The 43 women were placed in a control and treatment group. The treatment group received 11 sessions of group spiritual interventions. The women completed pretests and posttests to assess their symptoms. On the posttest, the treatment group exhibited a reduction in symptoms of traumatic stress. The researchers identified that the women discovered solace and healing in interaction with the Divine, safety in religious rituals, and comfort in predictable practices of their beliefs. The safe environment, permanency of the Creator's presence, and portability of spiritual skills gained in groups assisted clients in healing. These findings may prove applicable across various age groups after further studies. Finally, applying spiritual

interventions and participating in groups may also lead to alleviation of symptoms and offer therapists a cost-effective intervention for clients.

Present Study

The present study proposes correlations between sexually traumatic experiences, sexual shame, negative cognitions, and religiousness. The combination of the large number of women within churches and the large number of women sexually assaulted each year force a compelling look at ways religious communities can support healing and educate staff, survivors and volunteers about suffering around sexual shame and negative cognitions. In this study, the hypothesis is made that individuals have an increased experience of sexual shame following sexually traumatic experiences. Further, the study hypothesizes that negative cognitions rise with the experience of sexual shame. Finally, the study proposes that religiousness decreases sexual shame and negative cognitions for those with a history of sexually traumatic experiences. Langman and Chung (2013) found that spirituality, not forgiveness, alleviated trauma-induced stress symptoms. It is expected that this study on religiousness will provide results similar to Langman and Chung's (2013). Volk et al. (2016) found that pornography users growing up in religious households tended to be personally religious and struggle with pornography through the lens of moral disapproval. Thereby, their sexual shame scores were higher. There is an anticipated increased sexual shame related to sexually traumatic history; the hypothesis proposes that religiousness alleviates the sexual shame and negative self-cognitions.

Summary

A growing body of research promotes understanding of the variables surrounding CSA, shame, and religion. However, understanding the impact sexually traumatic events in a woman’s past have on her thought process and perceptions of God, self, shame, and spiritual beliefs is not

simplistic. Studies have used a broad scope to capture the types of sexually traumatic events women experience in society through coercion, pornography, abuse, sexual force, and violence (Aakvaag et al., 2016; Luquis et al., 2012; Reinert et al., 2015). The sexual shame women experience because of these events can limit the quality of the woman's life by directly changing her relationships with God and other people. The literature on sexual shame is robust in certain areas; however, the areas of impact of shame on relationships with God and others and how sexual shame erodes thinking of self and others have a great deal of opportunity for additional research. There is an opportunity to explore how sexual shame facilitates the development of negative thought patterns that change how a woman views her relationships. The investigations discussed in this chapter yielded important data regarding negative cognitions leading to depression, anxiety, and other mental disorders. The volume of literature documenting the relationship between negative cognitions and sexual trauma and spirituality is much less robust. This literature review has identified opportunities to study how many women responding to surveys suffer increased symptoms while practicing their faith. There is an open door to identify whether these women, impacted by shame and negative perceptions, also experience negative impacts in the practice of their faith. Collecting data and examining relationships can provide future researchers with a foundation for improved care of sexual abuse survivors.

CHAPTER THREE: METHODS

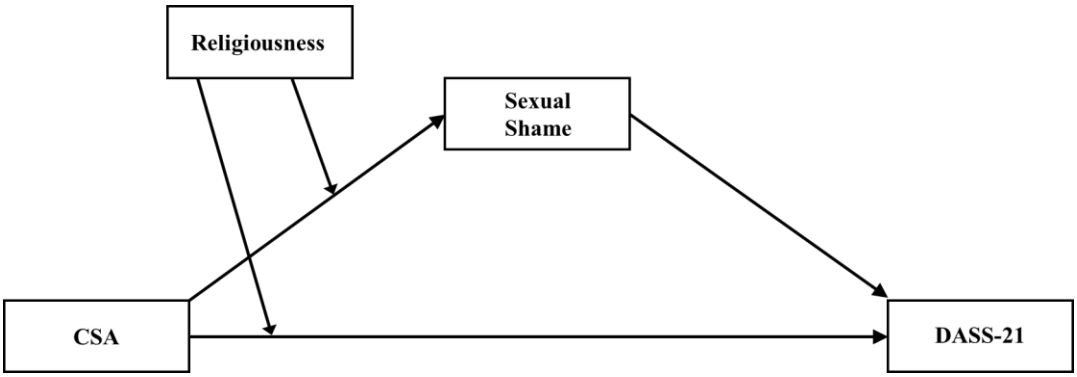
This chapter introduces the methods used in this research to evaluate the relationships and interactions between religiousness, history of CSA, sexual shame, and negative mental health outcomes (depression, anxiety, and stress). First, this study assesses whether a relationship exists between history of CSA and negative outcomes depression, anxiety, and stress. Second, this study assesses whether religiousness moderates the relationship between CSA history and negative mental health outcomes. Third, the data were evaluated to determine if the relationship between CSA history and negative outcomes is mediated by sexual shame. Finally, the study assesses the degree to which religiousness moderates the history of CSA-sexual shame-negative mental health outcomes causal sequence (see Figure 1).

This research aims to assess how religiosity strengthens or attenuates the history of CSA-sexual shame-negative mental health outcomes causal sequence in women. Ultimately, the results of this research can provide churches, mental health practitioners, and recovering women with empirically informed spiritual care to improve the quality of survivors' lives. In addition, the researcher aims to inform the religious community about improved spiritual care and outcomes. Also, the research may identify trends previously unknown to advance more research in the spiritual care of survivors of sexual trauma, including CSA.

Conceptual Model

Figure 1

Conceptual Model



Design

This study utilizes a nonexperimental cross-sectional design. There are no interventions applied to participants. The data were extracted from an existing dataset collected for a previous study. The analysis is a moderated-mediation model evaluating data responses regarding an overarching sequence of CSA, negative mental health outcomes, and sexual shame either strengthened or weakened by religiousness. In addition, this study seeks to measure data regarding relationships between CSA and negative outcomes moderated by religiousness. The ordinary least squares multiple regressions necessary to test the proposed models were generated via Hayes's (2018) PROCESS macro (Version 4).

Research Questions and Hypotheses

Research Question 1: Is there a relationship between dichotomous CSA and depression, anxiety, and stress?

Hypothesis 1a: A history of CSA is associated with higher levels of depression.

Hypothesis 1b: A history of CSA is associated with higher levels of anxiety.

Hypothesis 1c: A history of CSA is associated with higher levels of stress.

Research Question 2: Does religiosity moderate the relationship between the history of CSA and negative mental health outcomes?

Hypothesis 2a: Religiosity attenuates the negative effect of a history of CSA on depression.

Hypothesis 2b: Religiosity attenuates the negative effect of a history of CSA on anxiety.

Hypothesis 2c: Religiosity attenuates the negative effect of a history of CSA on stress.

Research Question 3: Does sexual shame mediate the relationship between the history of CSA and depression, anxiety, and stress?

Hypothesis 3a: There is a positive relationship between a history of CSA and sexual shame.

Hypothesis 3b: There is a positive relationship between sexual shame and increased symptoms of depression.

Hypothesis 3c: There is a positive relationship between sexual shame and increased symptoms of anxiety.

Hypothesis 3d: There is a positive relationship between sexual shame and increased symptoms of stress.

Hypothesis 3e1-3: Sexual shame mediates the relationship between a history of CSA and negative mental health outcomes (depression, anxiety, and stress).

Research Question 4: Does religiosity moderate the history of CSA-sexual shame-mental health outcomes causal sequence?

Hypothesis 4a: Religiosity strengthens the indirect relationship between a history of CSA and depression mediated by sexual shame.

Hypothesis 4b: Religiosity strengthens the indirect relationship between a history of CSA on anxiety mediated by sexual shame.

Hypothesis 4c: Religiosity strengthens the indirect relationship between a history of CSA on depression mediated by sexual shame.

Participants and Setting

The participant data included in this study are from females 19 years of age and older. The collection is cross-sectional for race and background with no upper age limit for inclusion. The women included further identified as religious, heterosexual, and are polled to determine dichomotous history of CSA. The archived data were collected through online surveys administered by Amazon Mechanical Turk (MTurk) on behalf of university researchers. MTurk is advantageous for use, as a large sample size is obtained efficiently. The population of interest partially informed the participant size and justified the study of women in churches. Using a standard *z* score of 1.96 as recommended in the sample size configuration guide presented by Warner (2011), the targeted sample size required for this study would be around 350 respondents. The desire was an extensive enough response to generalize the results for Christian women in America reporting past CSA.

The data from this study were drawn from an archival dataset. Participants were provided with informed consent when they completed the survey. The data were obtained by identifying respondents who answered positively for history of CSA. The data collected from participants were downloaded to IBM SPSS Statistics Version 27 for analysis.

Instrumentation

The first questions for the survey gathered primary demographic data to determine the cross-section respondents included in the data set. For example, the initial questions included

age, race, gender, religious affiliation, relationship status, and sexual orientation. The researcher intended to gather information from a broad demographic cross-section. Participants were required to be 19 or over to give legal consent as some states require. The data were assessed for outliers or respondents who were outside the identified target population. Women qualified for the study based on their self-identification of a history of CSA. A dichotomous item assessed CSA history. Other instruments used to assess data are discussed below.

Sexual Trauma Survey-Child Sexual Abuse

To be included in this study, participants identified their experience of CSA. A straightforward dichotomous assessment of CSA history was conducted. The question, "Have you experienced a history of child sexual abuse?" identified eligible participants. This question is sufficient to identify participants eligible for this study.

Religious Commitment Inventory

Religiousness comprises the importance of spirituality, moral values, and relationship to God as a person chooses to govern their course of living (Jaworski, 2015). Worthington et al. (2003) presented the RCI-10, which measures religious commitment through self-scoring. There are 10 questions scored on a 5-point Likert scale. The answer scale ranges from 1 ("not at all true of me") to 5 ("totally true of me"). The RCI-10 was developed by extracting 10 questions from the full RCI-17 measurement tool. These questions were pre-tested over three weeks for reliability and then made available to undergraduate students in a university psychology department. Reliability was further tested by Worthington et al. (2003) to compare the consistency among different religious groups, including Buddhist, Christian, Hindu, Muslim, and non-religious. In testing a married individual completing the RCI-10, the one-factor and two-factor models were determined to be replicated and good fit. The first administration and

subsequent three-week repeat administration yielded Pearson correlation coefficient scores of .87, .86, and .83, demonstrating reliability in the subscale Interpersonal Religious Commitment tool, and .93 for the full RCI-10. Cronbach's alpha scores range from .92 to .96 for various religions (Miller et al., 2013).

Worthington et al. (2003) developed the RCI-10 to evaluate religious practice in multiple groups and settings as concisely as possible. The RCI-10 (Worthington et al., 2003) is data-supported to assess research, psychological status, and counseling interactions. Worthington et al. (2003) stated the RCI-10 may be a time- and money-saving measure in research and practice. Miller et al. (2013) used the RCI-10 to effectively collect data in a study of adolescents and substance use with a slight modification to target respondents. The researchers were interested in noting if increased religious commitment dissuaded adolescents from the onset of use of substances. The results of this study prove the RCI-10 effective in identifying religious commitment for the age group specified. The current study requires evaluation of participants of a wide age range. Miller et al. (2013) provided data supporting the RCI-10 effectiveness for young women ages 18 and older in the RCI-A for adolescent scale with coefficient alpha scores ranging from .84 to .95 for various religions in adolescents.

The relationship between sexuality and religious commitment has been evaluated in research using the RCI-10. Abbott et al. (2016) used the RCI-10 to determine participants' level of religious commitment, proposing religious views may directly impact sexual self-esteem. The study cites previous findings that suggest increased religious commitment may negatively affect sexual satisfaction, specifically for women. Therefore, the researchers sought to define the impact of religious commitment further. The RCI-10 provided the researchers an effective

measurement of the increase or decrease in religious commitment for comparison with a variety of questionnaires regarding sexual attitudes and self-esteem self-reports.

Depression Anxiety Stress Scale 21

Negative cognitions are self-deprecating and uninvited thoughts that present to the individual in an internal conversation and evaluate the worth of the individual in a silent, unending commentary on self (Crandell & Chambless, 1986). Measures of negative cognition assess individuals' attitudes toward the internal value of self, the outside world, and possibly God. The DASS-21 comprises self-report assessments of the three areas of emotional state. Each of the three sections or subscales contains seven questions. Respondents answer the questions using a scoring range of 0 ("did not apply to me") to 3 ("applied to me very much"; Beaufort et al., 2017). Overall scoring for the sum of responses is 0 to 120. Scores for each area (depression, anxiety, and stress) fall between 0 and 42. The tool is noted to be helpful in research and clinical environments with high consistency and reliability. The DASS-21 has Cronbach's alpha scores of .81, .89, and .78 for the depression, anxiety, and stress subscales.

The DASS-21 is an instrument that can measure mental and emotional well-being across many cultures (Oei et al., 2013). The DASS-21 is a long-established assessment and data collection method in European, Australian, Hispanic, and Asian populations, among others (Oei et al., 2013). The DASS-21 seeks to measure the mental health and emotional response of participants. Therefore, the measure must appeal to the thoughts and emotions of individuals from various cultural backgrounds to produce effective data. Researchers have measured used the DASS-21 with adolescent through elder participants up to age 81 years, with strong validity for both age groups (Moore et al., 2017, Wood et al., 2010). The DASS-21 provides a strong measure of psychometric utility compared to other inventories. Lovibond and Lovibond (1995)

reported that the DASS-21, compared to other commonly used scales is a valid self-report inventory with reliability in assessing core symptoms in each area. The inclusion of stress symptoms in the DASS-21 allows the current study to evaluate a broader spectrum of participant responses regarding symptom experience. In addition, individual symptom factors can be evaluated to determine specific relationships between variables.

Kyle Inventory of Sexual Shame

The Kyle Invenory of Sexual Shame (KISS) is a 20-question questionnaire measuring sexual shame experiences as reported by respondents (Kyle, 2013). The 6-point Likert scale ranges from "1–strongly disagree" to "6–strongly agree." Kyle (2013) defined sexual shame as a painful, negative self-evaluation of value or worth secondary to sexual behavior, desire or experience that would be unacceptable to others. For this study, the brief KISS-9 survey (Jang, 2019) will be used to evaluate responses. The brief survey removes evaluation of cause and effect and measures experience of sexual shame. The KISS-9 has an internal consistency (Cronbach's alpha= .81 to .87. Respondents to the KISS-9 answer 5 question regarding thoughts about others and 4 regarding thoughts about self.

Measurement of the degree of self-reported sexual shame using the KISS has proven effective in recent studies. Marcinechová and Záhorcová (2020) investigated between sexual shame and several variables, including religiosity, sexual satisfaction, and sexual attitudes. The researchers found that sexual shame was positively related to shame-proneness and **negatively related to sexual satisfaction. These findings indicate a probable relationship between sexual** shame and negative emotional or mental outcomes. Pulverman and Meston's (2020) study indicates that sexual shame mediates the relationship between CSA and later adult sexual function. The current study specifically seeks to identify the mediating effects of sexual shame

for subjects with a positive history of child sexual abuse, particularly regarding negative mental health outcomes. Data from the development of the KISS provide support for the measure's consistency and reliability in evaluating respondents' degree of sexual shame. The KISS provides current, reliable data to evaluate the relationship between sexual shame, religiosity, and mental health outcomes for those who have experienced CSA.

Procedures

Institutional Review Board (IRB) approval was obtained prior to the collection of data used in this study. Archival data were originally collected from MTurk. Informed consent was required of participants prior to data collection. Participants were informed that the data they provided would be obtained anonymously regarding their religious practices, history of CSA, and depression, anxiety, and stress symptoms. Additionally, participants were made aware that data would be stored for research purposes only. Further, the participants notified that participation was entirely voluntary, and they could choose to exit at any point during the survey.

Data Analysis

Since the data were obtained from MTurk, they were evaluated and appropriately screened to prevent reduced data quality from impacting outcomes (Chmielewski & Kucker, 2020). Multiple regressions were used to address the research questions and hypotheses. Hayes's (2018) PROCESS macro (Version 4.0) with 5,000 bootstrap samples was used to generate regression coefficients and confidence intervals. There was an expectation that collinearity may exist imperfectly without violation of the linear assumption. This multicollinearity was anticipated due to the presence of mediation in the model. Bootstrapping was applied to address any non-normal distributions. Pearson's correlation was used to assess whether the present study's variables were correlated in expected ways.

Ethical Considerations

Ethical guidelines and recommendations by the IRB and American Counseling Association (2014) were applied to each step of the study development. Consideration was given to participants' privacy due to the sexual nature of questions, and the possible impact on respondents' mood change during the completion of the DASS-21 was evaluated (Osman et al., 2012). Additionally, care was taken to protect the anonymity and privacy of the participant. Therefore, no identifying information has been retained by this researcher for participants completing the surveys.

Summary

This chapter presents the methods used to research four questions regarding the relationship between CSA and negative mental health outcomes (depression, anxiety, and stress), how sexual shame mediates this relationship, and how religiosity moderates the CSA-sexual shame-negative mental health outcome causal sequence. The nonexperimental, moderated-mediation model used for this research does not involve the application of interventions. Data were collected from women 19 years of age and older with no age cap from surveys completed on MTurk. The archival data were taken from a larger university study, and IRB approval and participant consent were verified. The instruments used in the study were evaluated for verified reliability and consistency. The DASS-21 (Oei et al., 2013) is used to evaluate negative mental health outcomes. The RCI-10 (Worthington et al., 2003) is used to evaluate the daily life religious commitment of the women participating in the research. The women also complete the KISS (Kyle, 2013) to report sexual shame scores. There is dichotomous question regarding experience of CSA. The data were analyzed to verify assumptions and expected interactions

were met. Ethical considerations were discussed, and care is taken to protect the privacy of the participants.

CHAPTER FOUR: FINDINGS

Overview

This chapter aims to describe the data and statistical findings of this research. First, the demographics and distribution of the respondents will be introduced in this chapter. Next, a discussion of the descriptive statistics will be presented. This information will be followed by an exploration of the models used to determine internal consistency of the data. Finally, the chapter will discuss and summarize the findings noted within the research.

Demographics

The participants in this study were screened for exclusion due to missing data, incomplete responses, and demographic selection ≥ 19 years and female. The final sample size yielded is N = 751 participants. The age range was 19 to 76 years, with a mean age of 36.61 years. The sample was 76.0% White, 10.9% Black or African American, 0.4% Native American or Alaska Native, 5.5% Asian or Asian American, 0.4% Hawaiian or other Pacific Islander, 5.6% Hispanic or Latino, and 1.2% other for final data analysis. Of these participants, 22.2% or 167 participants reported a history of CSA. Of the participants, 6.5% reported their relationship status as single and never in a relationship, 12.3% single but have had a past relationship, 3.1% in a non-committed dating relationship, 17.3% in a monogamous dating relationship, 54.5% married or with a life partner, 1.1% legally separated, 3.7% divorced, and 1.6% widowed. Participants' religious affiliations were Protestant (18.9%), Catholic (31.6%), nondenominational Christian (15.7%), Mormon (0.7%), Muslim (1.3%), Hindu (2.0%), Jewish (0.9%), Buddhist (0.7%), New Age Wiccan (1.3%), Taoist (0.3%), none (22.1%), and other (4.5%).

Descriptive Statistics

Cronbach's alpha scores for all scales were sufficient at >.70, and the results for the study variables are as follows: RCI-10 = .965, KISS-9 = .924, DASS-Depression = .938, DASS-Anxiety = .913, and DASS-Stress = .904. These scores reflect adequate reliability for the research study as planned. Pearson's correlation was used to determine whether the variables correlated as expected. CSA was positively correlated with sexual shame, depression, anxiety, and stress. The results of the Pearson's correlation revealed that CSA has a significant positive correlation with sexual shame ($r = .095$, $p < .01$), depression ($r = .87$, $p < .05$), anxiety ($r = .106$, $p < .01$), and stress ($r = .088$, $p < .05$). These results were consistent with researcher expectations. However, contrary to expectations, CSA was not found to be significantly correlated with religiosity ($r = .318$, $p < .01$). Sexual shame was found to be significantly positively associated with depression ($r = .609$, $p < .01$), anxiety ($r = .655$, $p < .01$), stress ($r = .597$, $p < .01$), and religiousness ($r = .318$, $p < .01$). While religiosity was not found to be significantly correlated with CSA, religiosity was found to be positively correlated with depression ($r = .141$, $p < .01$), anxiety ($r = .379$, $p < .01$), and stress ($r = .225$, $p < .01$). Data analysis revealed normal distribution with no violation of regression assumptions. The relationships are linear in nature and are independent within the data set. Homoscedasticity is present within the distance between residuals. Assumptions are satisfied for multiple linear regression analysis. These findings serve as the basis for further analysis using Hayes (2018) Model 8 conditional PROCESS analysis for moderated mediation.

Table 1

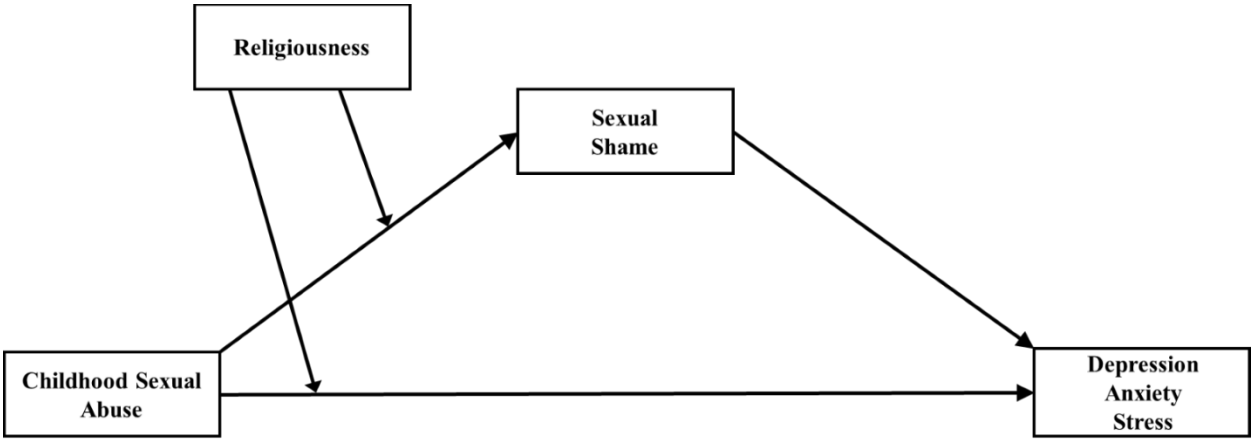
Pearson's r, *Means, and Standard Deviations*

	1	2	3	4	5	6
(1) CSA	1					
(2) KISS-9	.095**	1				
(3) Depression	.087*	.609**	1			
(4) Anxiety	.106**	.655**	.760**	1		
(5) Stress	.088*	.597**	.815**	.824**	1	
(6) RCI-10	.055	.318**	.141**	.379**	.225**	1
Mean	.222	3.475	14.698	11.771	15.808	2.559
SD	.416	1.622	12.391	11.264	11.042	1.300
Cronbach's α		.924	.938	.913	.904	.965

*Correlation is significant at the .05 level (2-tailed).
**Correlation is significant at the .01 level (2-tailed).

Figure 2

Conceptual Model



Results

Model 1: Depression

Figure 3

Moderated Mediation Model for Depression

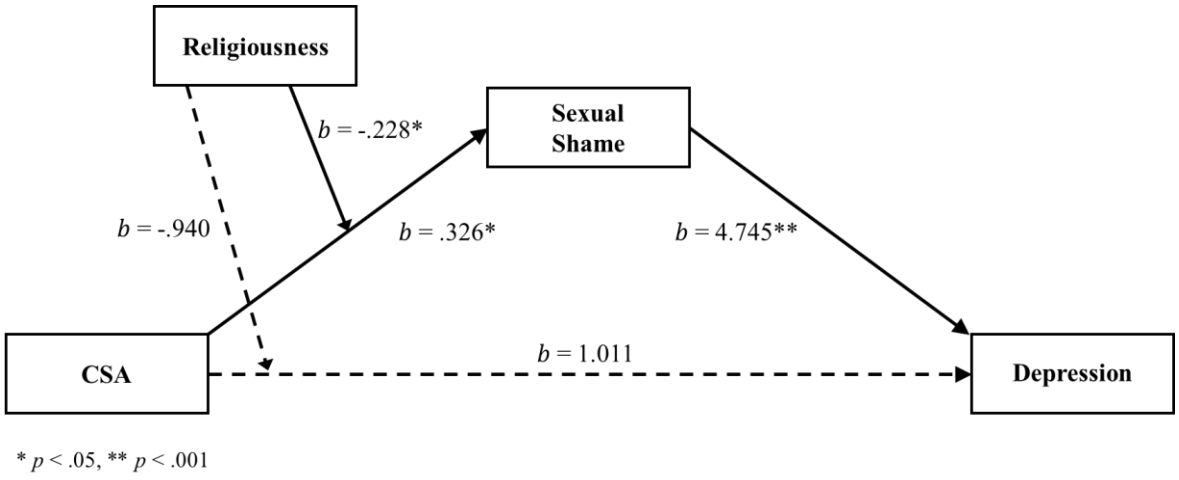


Table 2

Moderated Mediation Model for Depression

					95% CI	
Source	*b*	*SE*	*T*	*p*	*LL*	*UL*
Sexual Shame: R = .335, R^2 = .113, MSE = 2.345, F(3, 747) = 31.572, p < .001						
CSA	0.326	.135	2.414	<.050	0.061	0.591
Religiousness	0.388	.043	9.012	<.001	0.304	0.473
CSA X Religiousness	-0.228	.106	-2.154	<.050	-0.435	-0.020
Depression: R = .613, R^2 = .376, MSE = 96.307, F(4, 746) = 112.404, p = <.001						
CSA	1.011	.868	1.164	.245	-0.694	2.716
Sexual Shame	4.745	.234	20.238	<.001	4.285	5.206
Religiousness	-0.568	.291	-1.953	.051	-1.139	0.003
CSA X Religiousness	-0.940	.679	-1.384	.167	-2.274	0.394

Sexual Shame

The results show both CSA and religiosity had a significant positive effect on sexual shame. Additionally, the interaction between CSA and religiosity (moderation) was found to transmit a significant negative effect on sexual shame. The findings indicate that religiosity

moderated the effect of CSA on sexual shame. This suggests the level of effect may vary at different levels of religiosity. This finding indicates that the interaction (CSA X Religiosity) is responsible for 0.6% of the variance on sexual shame scores. This finding can inform future research considerations and could be valuable to understanding how the practice of religion influences the sexual trauma survivor and their management of sexual shame and possible other negative experiences secondary to CSA.

The researchers further conducted a test of conditional effects at values of religiosity (16th, 50th, and 84th percentiles), revealing a significant effect conditioned on low (16th percentile) to moderate (50th percentile) levels of religiosity. There was no significant effect at high (84th percentile) levels of religiosity. Expressly, at low (b = .681, SE = .221, 95% CI [.247, 1.115]) and moderate (b = .317, SE = .135, 95% CI [.052, .581]) levels of religiosity, CSA is noted to transmit a significant positive effect on sexual shame with the strength of effect declining at higher levels of religiosity. This finding indicates that higher scores of religiosity weaken the effect. This suggests that religiosity attenuates the negative effect of CSA on sexual shame.

Depression

The results of this research reveal that CSA did not have a significant direct effect on depression; however, sexual shame was found to transmit a significant positive effect on depression. Religiousness was not found to have a significant effect on depression. The interaction of CSA and religiosity (moderation) was not found to transmit a significant effect on depression. Thus, findings do not support that religiosity moderates the effect of CSA on depression. There is support for a conditional indirect effect of CSA on depression through sexual shame in which the effect varied significantly as a product of religiosity. The indirect

effect of CSA on depression, through mediation by sexual shame (*b* = -1.080, BootSE = .552, 95% CI [-2.204, -0.028]) is moderated by religiosity. Specifically, findings show that the indirect effect is conditioned on low (16th) to moderate (50th) religiosity with the effect not being significant at high (84th) levels of religiosity. More specifically, at low (*b* = 3.231, *SE* = 1.072, 95% CI [1.155, 5.423]) and moderate (*b* = 1.502, *SE* = .677, 95% CI [0.204, 2.869]) levels of religiosity, CSA is found to transmit a significant positive effect on depression, with the strength of this effect decreasing at higher levels of religiousness. This suggests that at higher levels of religiousness, the effect becomes weaker, indicating that religiosity attenuates the negative effect of CSA on depression.

Model 2: Anxiety

Figure 4

Moderation Mediation Model for Anxiety

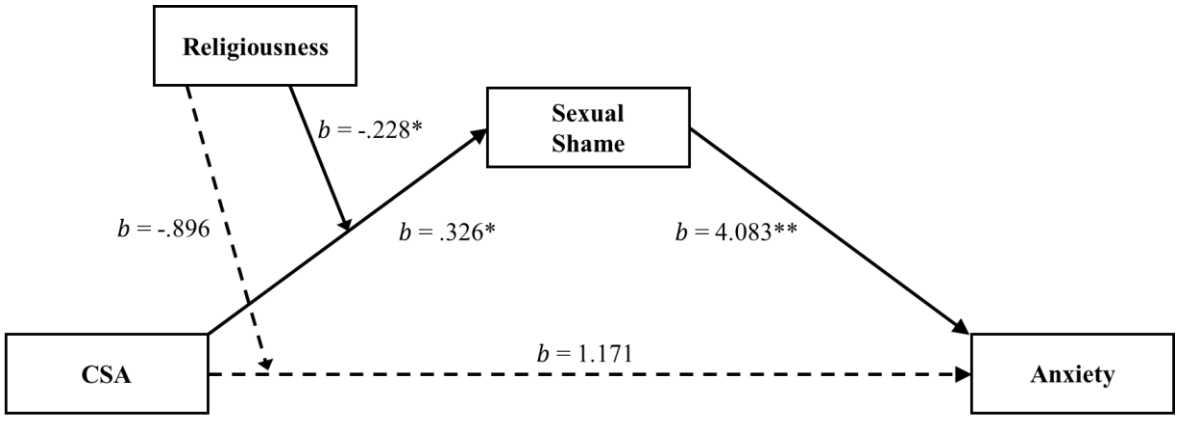


Table 3

Moderated Mediation Model for Anxiety

					95% CI	
Source	*b*	*SE*	*T*	*p*	*LL*	*UL*
Sexual Shame: $R = .335$, $R^2 = .113$, $MSE = 2.345$, $F(3, 747) = 31.572$, $p < .001$						
CSA	0.326	.135	2.414	<.050	0.061	0.591
Religiousness	0.388	.043	9.012	<.001	0.304	0.473
CSA X Religiousness	-0.228	.106	-2.154	<.050	-0.435	-0.020
Anxiety: $R = .682$, $R^2 = .465$, $MSE = 68.242$, $F(4, 746) = 162.087$, $p = <.001$						
CSA	1.171	.731	1.602	.109	-0.264	2.606
Sexual Shame	4.083	.197	20.688	<.001	3.696	4.471
Religiousness	1.631	.245	6.663	<.001	1.150	2.111
CSA X Religiousness	-0.896	.572	-1.567	.118	-2.019	0.227

Sexual Shame

The results show both CSA and religiosity had a significant positive effect on sexual shame. Additionally, the interaction between CSA and religiosity (moderation) was found to transmit a significant negative effect on sexual shame. The findings indicate that religiosity moderated the effect of CSA on sexual shame. This suggests the level of effect may vary at different levels of religiosity. This finding indicates that the interaction (CSA X Religiosity) is responsible for 0.6% of the variance on sexual shame scores.

The researchers further conducted a test of conditional effects at values of religiosity (16th, 50th, and 84th percentiles), revealing a significant effect conditioned on low (16th) to moderate (50th) levels of religiosity. There was no significant effect at the high (84th) level of Religiosity. Expressly, at low ($b = .681$, $SE = .221$, 95% CI [.247, 1.115]) and moderate ($b = .317$, $SE = .135$, 95% CI [.052, .581]) levels of religiosity, CSA was noted to transmit a significant positive effect on sexual shame with the strength of effect declining at higher levels of religiosity.

This finding indicates that higher religiosity scores weaken the effect and suggests that religiosity attenuates the negative effect of CSA on sexual shame.

Anxiety

The data produced from this study reveal CSA did not have a significant direct effect on anxiety. However, sexual shame was noted to have a significant positive direct effect on anxiety. Religiosity was found to have a significant positive effect on anxiety. The interaction between CSA and religiosity (moderation) does not transmit a significant positive effect on anxiety. Hayes's (2018) index models of moderated mediation indicate that there is no significant effect of CSA on anxiety (*b* = -.930, BootSE = .479, 95% CI [-1.868, .002]). In contrast to the depression model, findings did not support moderated mediation, and no support was found for a significant direct or indirect effect of CSA on anxiety.

Model 3: Stress

Figure 5

Moderated Mediation Model for Stress

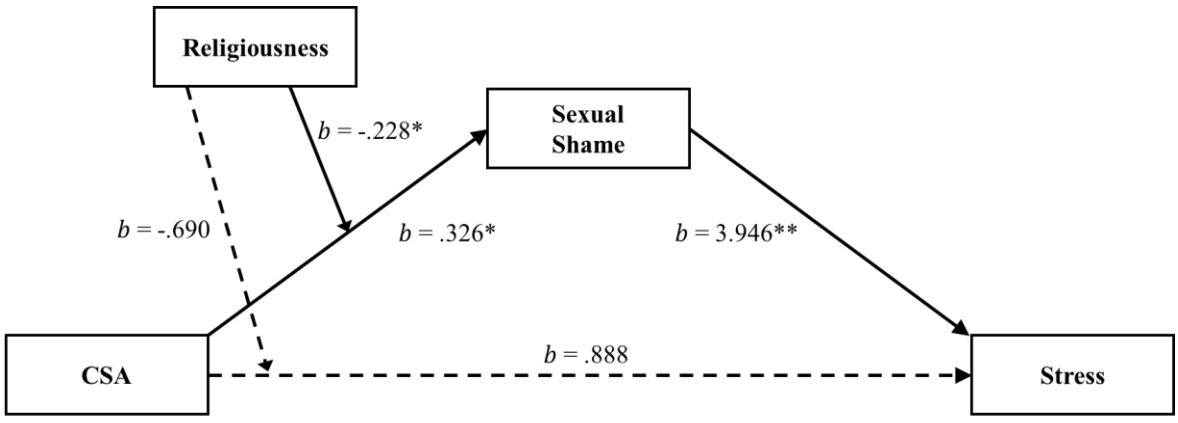


Table 4

Moderated Mediation Model for Stress

					95% CI	
Source	*b*	*SE*	*T*	*p*	*LL*	*UL*
Sexual Shame: $R = .335$, $R^2 = .113$, $MSE = 2.345$, $F(3, 747) = 31.572$, $p < .001$						
CSA	0.326	.135	2.414	<.050	0.061	0.591
Religiousness	0.388	.043	9.012	<.001	0.304	0.473
CSA X Religiousness	-0.228	.106	-2.154	<.050	-0.435	-0.020
Stress: $R = .600$, $R^2 = .360$, $MSE = 78.399$, $F(4, 746) = 105.074$, $p = <.001$						
CSA	0.888	.784	1.113	.258	-0.650	2.426
Sexual Shame	3.946	.212	18.653	<.001	3.531	4.362
Religiousness	0.320	.262	1.221	.222	-0.195	0.835
CSA X Religiousness	-0.690	.613	-1.125	.261	-1.893	0.514

Sexual Shame

The results show both CSA and religiosity had a significant positive effect on sexual shame. Additionally, the interaction between CSA and religiosity (moderation) was found to transmit a significant negative effect on sexual shame. The findings indicate that religiosity moderated the effect of CSA on sexual shame. This suggests the level of effect may vary at different levels of religiosity. This finding indicates that the interaction (CSA X Religiosity) is responsible for 0.6% of the variance on sexual shame scores.

The researchers further conducted a test of conditional effects at values of religiosity (16th, 50th, and 84th percentiles), revealing a significant effect conditioned on low (16th) to moderate (50th) levels of religiosity. There was no significant effect at high (84th) levels of Religiosity. Specifically, at low ($b = .681$, $SE = .221$, 95% CI [.247, 1.115]) and moderate ($b = .317$, $SE = .135$, 95% CI [.052, .581]) levels of religiosity, CSA was noted to transmit a significant positive effect on sexual shame, with the strength of effect declining at higher levels

of religiosity. This finding indicates that higher scores of religiosity weaken the effect. This suggests that religiosity attenuates the negative effect of CSA on sexual shame.

Stress

The results show that CSA did not have a significant direct effect on stress; however, sexual shame was found to transmit a significant positive effect on stress. Unlike the previous models (Depression and Anxiety), religiosity was not found to have a significant effect on stress. The interaction of CSA and religiosity (moderation) was not found to transmit a significant effect on stress. That is, findings did not support that religiousness moderated the effect of CSA on stress. Support was found for a conditional indirect effect CSA on stress through sexual shame, in which the effect varied significantly as a product of religiosity. Moderated mediation indicates that the indirect effect of CSA on stress through sexual shame is moderated by religiosity (*b* = -.898, BootSE = .457, 95% CI [-1.779, -.027]). Specifically, findings show that the indirect effect is conditioned on low (16th) to moderate (50th) religiousness, with the effect not being significant at high (84th) levels of religiousness. More specifically, at low (*b* = 2.687, *SE* = .915, 95% CI [.935, 4.578]) and moderate (*b* = 1.249, *SE* = .568, 95% CI [.139, 2.386]) levels of religiosity, CSA is found to transmit a significant positive effect on stress, with the strength of this effect decreasing at higher levels of religiosity. This suggests that at higher levels of religiosity, the effect becomes weaker, indicating that religiosity attenuates the negative effect of CSA on stress.

Summary

This research examines the relationships between CSA history and the negative mental health outcomes of depression, anxiety, and stress. Further, the study seeks to analyze the moderating effect of religiosity and the mediating effect of sexual shame on these relationships.

The investigation did not support a significant moderating relationship between CSA, religiosity, and the mental health symptoms of depression, anxiety, and stress. However, the analysis of the moderating mediation revealed a significant effect between CSA, religiosity, sexual shame, and depression and anxiety. Sexual shame exhibited a significant positive effect in the analysis of stress symptoms, but there was no significant moderating effect between religiosity and stress symptoms. In each of the three dependent variables, there was an indirect effect attenuation of the negative relationship between CSA and depression, anxiety, and stress symptoms mediated through sexual shame. As religious commitment increased, the effect of CSA on symptoms of depression, anxiety, and stress decreased. These findings will inform future studies after careful consideration of the limitations and appropriate implications of the data analysis.

CHAPTER FIVE: CONCLUSION

The current research examines the relationship between a history of CSA and the negative mental health outcomes of depression, anxiety, and stress in women. Further, the study sought to identify the impact of religiosity as a moderating factor and sexual shame as a mediator in the relationship between CSA and the negative outcomes of depression, anxiety, and stress. Though previous studies have produced results regarding the non-physical impact of CSA, no study at present has explored the indirect relationship between CSA and mental health outcomes mediated by sexual shame and religiosity as a moderator of the effects (Lyon, 2010; Tran et al., 2019). The negative impact of CSA is well researched (Mathews & Collin-Vezina, 2019; Ng et al., 2018; Shchupak, 2015). However, evidence-based analyses of the impact of religious practices could provide support for future studies to decrease survivor symptoms and increase researchers' understanding of the benefits of religious practices for those recovering from CSA, sexual shame, and cascading mental health issues (Ahrens et al., 2010; Mathews & Collin-Vezina, 2019*).* The research questions were arranged as an overarching moderated mediation regression model with hypotheses analyzing the impact of religiosity and sexual shame on three dependent variables: depression, anxiety, and stress symptoms.

The study was conducted using archived data collected from MTurk surveys. The specific focus of the study was female subjects, who answered a dichotomous question regarding their history of CSA. The study met all applicable assumptions, and variable Cronbach's alpha scores are sufficient to support relationships. The findings related to the original question regarding the direct relationship between CSA and negative outcomes, including depression, anxiety, and stress, did not reveal a significant direct relationship between CSA and depression or anxiety. However, the data analysis did find several interesting relationships between these

negative outcomes and CSA through moderated mediation with sexual shame and religiosity. This chapter provides the reader with the conclusions drawn from the research. The limitations of the study are also explored. For example, all respondents were female, so no data regarding men is available. Finally, the implications and future research recommendations are presented.

Discussion of Findings

This study aimed to determine a relationship between CSA history and the negative mental health outcomes of depression, anxiety, and stress. The research also evaluated religiosity as a moderator of CSA for negative mental health outcomes. Then, the study investigated the possible moderating mediation effect of religious commitment and sexual shame for those with a history of CSA and negative mental health symptoms. The inclusion criteria of this study allowed an archival target population ($N = 751$) to be gleaned from a more extensive university study to examine the data regarding these correlations. The data set was screened for missing and incomplete responses, and all applicable assumptions were met for analysis.

The original research question sought to identify a relationship between CSA history and the negative mental health outcomes depression, anxiety, and stress. The second question posed in the research investigated the moderating relationship between religious commitment, CSA, and negative mental health outcomes. The third relationship the study sought to identify was the possible mediating relationship of sexual shame between CSA and depression, anxiety, and stress. Finally, this study sought to determine whether religiosity moderates the history of CSA-sexual shame-mental health outcomes causal sequence.

Correlation Analysis

The Pearson's correlation results of this research supported a relationship between CSA and negative mental health outcomes depression ($r = .087$, $p < .05$), anxiety ($r = .106$, $p < .01$),

and stress (r = .088, p < .05). CSA was also found to have a significant positive relationship to sexual shame (r = .095, p < .01). Conversely, CSA did not have a significant relationship with religiosity (r = .055, p > .05). Sexual shame was noted to be positively correlated with depression (r = .609, p < .01), anxiety (r = .655, p < .01), stress (r = .597, p < .01), and religiousness (r = .318, p < .01). While religiousness was not found to be significantly correlated with CSA, it was found to be positively correlated with Depression (r = .141, p < .01), anxiety (r = .379, p < .01), and stress (r = .225, p < .01). These results provided a solid foundation to support the research models discussed in this chapter.

Research Question 1

The first research question asked whether a history of CSA is associated with higher depression, anxiety, and stress. The data did not support a direct relationship between CSA (b = 1.011, SE = .868, 95% CI [-0.694, 2.716]) and increased depression, anxiety, and stress symptoms. However, there is some evidence in the literature regarding the impact of CSA on mental health outcomes of various types (Karatzias et al., 2018; Ng et al., 2018). The findings in this study may be influenced by the larger-scale study questions not included in this investigation. The sample for this study is limited to only female respondents and allowed a large age range: 19 to 76 years old. Therefore, age or time since abuse may impact the respondents' experience. Finally, the respondent's state at the time of the survey completion can impact the self-report of symptoms. Implications of the current study must be considered in light of these factors.

The study identified that CSA (b = .326, SE = .135, 95% CI [0.061, 0.591]) had a positive effect on sexual shame. This is an interesting finding due to the implications of sexual shame on mental health outcomes. Sexual shame transmitted a significant positive effect on depression

(*b* = 4.745, *SE* = .234, 95% CI [4.285, 5.206]), anxiety (*b* = 4.083, *SE* = .197, 95% CI [3.696, 4.471]), and stress (*b* = 3.946, *SE* = .212, 95% CI [3.531, 4.362]). Therefore, despite the absence of evidence to support a direct relationship between CSA and negative mental health outcomes in the current research, there is some evidence that warrants further investigation of these relationships**.**

Research Question 2

The second research question sought to determine if religiosity moderates the relationship between the history of CSA and negative mental health outcomes for women. The interaction of CSA and religiousness (moderation) was not found to transmit a significant effect on depression (*b* = -0.940, *SE* = .106, 95% CI [-.435, -.020]), anxiety (*b* = -0.896, *SE* = .572, 95% CI [-2.019, .227]), or stress (*b* = -0.690, *SE* = .613, 95% CI [-1.893, 0.514]) scores directly. However, results did reveal depression and stress scores were higher for those with history of CSA and sexual shame at lower to moderate religiosity levels. This indicates an indirect effect is present. The strength of increased religiosity weakens depression and stress scores attenuating the relationship**.** These findings support attenuation of depression and by religiosity indirectly when CSA and sexual shame are present and prompt further study. In contrast, religiosity was noted to have a significant positive direct effect on anxiety (*b* = 1.631, *SE* = .245, 95% CI [1.150, 2.111]). The implications of this relationship between religiosity and anxiety warrant a closer study to determine other contributing factors that may be at play in this finding as well as possible inferences.

Research Question 3

The third question of the research study investigated the relationship between sexual shame as a mediator of the relationship between the history of CSA and depression, anxiety, and

stress. Sexual shame was found to transmit a significant positive effect on depression (b = 4.745, SE = .234, 95% CI [4.285, 5.206]), anxiety (b = 4.083, SE = .197, 95% CI [3.696, 4.471]), and Stress (b = 3.946, SE = .212, 95% CI [3.531, 4.362]) scores. These findings confirm a mediating effect on depression, anxiety, and stress scores for women with a history of CSA (Talbot et al., 2004). These findings are consistent with findings in published literature. Expansion of the research to determine how sexual shame exerts an increase for depression, anxiety, and stress scores may provide interesting results. Further investigation within this study found that the interaction between CSA and religiousness (moderation) was found to transmit a significant negative effect on sexual shame (b = -0.228, SE = .106, 95% CI [-0.435, -0.020]). That is, findings supported that religiousness moderated the effect of CSA on sexual shame, suggesting the effect varies at levels of religiousness. Results showed that the interaction (CSA x Religiousness) accounted for 0.6% of the variance in sexual shame. These findings indicate that religiosity may attenuate the experience of sexual shame for those recovering from CSA and empower individuals to pursue spiritual means of healing to support their treatment plan.

Research Question 4

The final question researched in the study examined the role of religiosity as a moderator of the history of CSA-sexual shame-mental health outcomes causal sequence. The index of moderated mediation indicated that the indirect effect of CSA on depression (b = -1.080, BootSE = .552, 95% CI [-2.204, -0.028]) and stress (b = -0.898, BootSE = .457, 95% CI [-1.779, -0.027]) through sexual shame was moderated by religiousness (Hayes, 2018). Conversely, no significant effect was proven through moderated mediation for anxiety (b = -0.930, BootSE = .479, 95% CI [-1.868, 0.0020]) symptoms. These findings indicate a relationship between history of CSA and

sexual shame to increase depression and stress symptoms that may then be attenuated at higher levels of religious commitment for the individual.

The moderating mediation was further determined to occur at three different levels of religiosity. Low, moderate, and high levels of religiosity were examined; high levels had an overall attenuating relationship. More specifically, at low (b = 3.231, SE = 1.072, 95% CI [1.155, 5.423]) and moderate (b = 1.502, SE = .677, 95% CI [0.204, 2.869]) levels of religiousness, CSA was found to transmit an increase of depression scores, with the strength weakening as the level of religiosity increased. Similar findings regarding stress were noted at low and moderate levels. Specifically, findings showed that the indirect effect was conditioned on low (16th) to moderate (50th) religiousness, with the effect not being significant at high (84th) levels of religiousness. More specifically, at low (b = 2.687, SE = .915, 95% CI [0.935, 4.578]) and moderate (b = 1.249) scores, stress scores increased as religiosity decreased. This provides support for spiritual practices in individuals' lives as a way of alleviating or at least decreasing some of the negative emotional responses in the lives of CSA survivors.

Implications

The research presented in this study began a primary investigation of the relationship between the history of CSA and the negative outcomes of depression, anxiety, and stress. The model further evaluated the relationship of religious commitment on the interaction between CSA and negative outcomes. In addition, this study sought to identify the statistical relationship of sexual shame on CSA and negative outcomes. Moreover, expanding the research, the model included religiosity as a moderator of the causal sequence of history of CSA-sexual shame-mental health outcomes. Not all these relationships interacted as expected in the hypothesized model. For example, the proposed direct relationship between CSA and adverse outcomes was

not supported. However, the results, particularly the causal sequence moderated mediation relationship, supported religiosity as a moderator of symptoms in low to moderate sexual shame. This finding could inform counselors, religious leaders, and other helping professionals working with individuals surviving CSA.

Biblical Perspective

These findings could impact counseling, pastoral care, and the Christian worldview. Spiritual care can improve individuals' quality of life by reducing their experience of shame and adverse outcomes through increased religious commitment and connection in the community.

This research supports the importance of religious community in the process of healing from CSA and associated negative experiences such as shame, depression, anxiety, and stress. As a religious practice based on the Bible, Christianity is not silent regarding sexuality, shame, relationships, or the human thought life. Sexual assault is directly discussed on numerous occasions in Scripture. For example, God addresses the innocence of rape victims, the guilt of the perpetrator, and the role of judges to protect the community in Leviticus 18:5–18 and Deuteronomy 22:25–27. Further, coercion in rape is addressed in Dinah's rape in Genesis 34:1–3, and violent consequences to a whole community are seen. Finally, 2 Samuel 13 discusses the incestuous rape of Tamar by Amnon and the resulting conflict in King David's household. Though these behaviors and criminal acts are not new, research-informed care and an understanding of the biblical perspective of sexual assault can provide a holistic recovery for survivors.

Escalation of emotions may drive various unhealthy responses in individuals who experienced early or repeated sexual trauma (Rind et al., 1998). However, the Bible offers solutions for healing for a spiritually robust life. According to Genesis 2:25, God did not create

humankind to endure shame; the man and woman were able to live nude and altogether avoid the presence of shame in their lives. Shame entered humanity after sin, which caused Adam to hide from God what he perceived made him unacceptable before the Father (Genesis 3:8). This separation caused by shame could only be resolved through justification through Christ alone (Romans 3:22). God has, from the beginning, planned the redemptive healing of man's spirit, mind, body, and soul (Genesis 3:14–15). Psalm 34:5 describes people looking to God for help and being radiant, joyful, and without shame. Strong (1890) defined "being ashamed" as a feeling of being imperfect or reproached. Isaiah 61:7 says God gives a double portion instead of shame. Shame, depression, anxiety, and stress are not how God designed people to live.

Finally, Hebrews addresses Jesus's perspective: He despised the shame and suffered it only for the joy of cleansing humanity from sin and unhealthy lives. Strong (1890) identified shame in Hebrews 12:2 as a noun meaning disgrace. Clarke and Earle (1967) commented that Jesus's management of shame is humanity's example; He did not remain in disgrace but instead went through the experience of shame and fixed His eyes on God's will and righteousness. Scripture concludes that remaining caught in the quagmire of shame and negative emotional symptoms from past experiences is not God's will. Galatians 5:1 states that humanity has been set free for freedom's sake. Therefore, churches and helping professionals must research and become proficient in their knowledge of the impact of spiritual practices on the alleviation or exacerbation of these negative emotional outcomes on individual lives.

Limitations

The implications of this study are limited in several areas that must be discussed for possible future research. First, as previously mentioned, the data reported in this research were gathered from a sample limited to women 19 years of age and older. Therefore, no inferences can

be made regarding male CSA survivors or underage symptoms related to CSA. The data were also collected from a larger university-archived data set; therefore, other survey data collected could impact the answers provided by recruited participants based on how other survey assessments affected the individual. For example, a participant may have been tired or hurried in answering these questions during the survey. Finally, religious commitment is noted to be significant only in low- to middle-ranking sexual shame experiences. Therefore, the experience of high levels of shame warrants continued research before the benefit of religious practice in treatment plans can be inferred.

Recommendations for Future Research

There are several opportunities to expand the research regarding religiosity, shame, and adverse outcomes related to CSA. First, there should be consideration of a mixed-gender study. Information regarding the experience of men after CSA is less robust and needed in the literature. Also, the public would benefit from a study of differences of benefit of various religious communities for CSA survivors. For example, do specific religious communities benefit CSA survivors more or less than others? In addition, are there certain religious practices, such as prayer, Bible memorization, and small group involvement that are more or less beneficial than other practices? Furthermore, consideration should be given to studying the impact of religion on child survivors of CSA. For example, is spiritual practice beneficial to the healing process for child survivors? Understanding more about spiritual practices in healing could benefit all ages, genders, and faith communities. The data from this and similar studies may also yield beneficial qualitative results informing a better understanding of outcomes and treatment. The demographic and experiential data collected from CSA survivors may benefit counselors, researchers, and spiritual care providers to understand the needs of and opportunities to care for

women after CSA. Finally, experiential research of adult experiences of sexual shame, religious practices, and mental health outcomes for CSA survivors could serve to better inform researchers and support the development of effective interventions for survivors.

Summary

This chapter provides insight into the conclusions and implications of the current research study. The researchers endeavored to determine the role of religiosity to attenuate or exacerbate possible negative outcomes of depression, anxiety, and stress for CSA survivors mediated through sexual shame. This research provided interesting conclusions, negating some expected direct relationships and confirming attenuation of symptoms in moderated mediation at low and moderate levels of shame. Higher religious commitment decreased the experience of shame and, therefore, adverse outcomes. This chapter provided a discussion of the limitations of the researcher's inferences and suggestions for possible study expansion. This study demonstrated a mediation effect between CSA history and the negative outcomes of depression, anxiety, and stress through sexual shame conditioned on religiosity. The results support the attenuating effect of religiosity on the negative outcome symptoms of depression, anxiety, and stress for those with a history of CSA as the level of religiousness increases. These findings certainly illuminate a need for continued research to determine the value of religious practice in the lives of CSA survivors in conjunction with treatment and counseling for sustained recovery and quality of life improvement.

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APPENDIX A

Dichotomous Child Sexual Abuse

Do you have a history of child sexual abuse? _____yes _____no

APPENDIX B

Religious Commitment Inventory (Worthington et al., 2003)

APPENDIX C

Depression Anxiety Stress Symptoms- 21

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APPENDIX D

Kyle Inventory of Sexual Shame-9 (Jang, 2019)