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Sexual Victimization: An Examination of Variables Predicting Psychological Adjustment

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SEXUAL VICTIMIZATION: AN EXAMINATION OF VARIABLES
PREDICTING PSYCHOLOGICAL ADJUSTMENT

by

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SEXUAL VICTIMIZATION: AN EXAMINATION OF VARIABLES PREDICTING PSYCHOLOGICAL ADJUSTMENT

Janine M. Schroeder, Ph.D.
Western Michigan University, 2005

A survey was conducted with a community sample of 208 women. Participants completed a battery of self-report measures that assessed childhood sexual abuse (CSA), adult sexual victimization (ASV), characteristics of the abuse, coping methods, PTSD symptomatology, and psychological distress. One-way analysis of variance (ANOVA) procedures revealed that victims were significantly more distressed than nonvictims; revictimized women and multiple victims were significantly more distressed than nonvictims; revictimized women were significantly more distressed than single victims; differences between multiple and single victims and single victims and nonvictims were not significant. Multivariate analysis of variance (MANOVA) analyses indicated victims reported significantly more frequent use of disengagement coping strategies, specifically, emotion focused disengagement strategies, than nonvictims. MANOVA procedures demonstrated significant differences between type of stressor and method of coping employed among victims of CSA and/or ASV. Specifically, engagement coping was utilized more often in response to non-abuse stressors and disengagement coping to deal with the aftermath of sexual victimization. Multiple regression analyses indicated that strategies utilized
to cope with CSA accounted for unique variance in psychological distress, even after controlling for characteristics of the abuse experience and methods of coping with nonabuse stressors. Multiple regression analyses demonstrated that psychological distress was predicted by disengagement methods of coping, a history of CSA, characteristics of the abuse experience, and treatment history related to sexual abuse. An independent-samples t-test indicated a significant difference in levels of distress between victims of CSA who experienced an abusive situation with a higher degree of threat or force utilized compared to a lower degree of force. Independent-samples t-tests indicated no significant differences in distress levels for victims related to the following characteristics of the abuse experience: age, duration, frequency, level of sexual activity, and relationship of the perpetrator to the victim. Finally, MANOVA analyses demonstrated that victims’ distress levels did not differ significantly when considering treatment-seeking behavior in general; however, differences were apparent when examining treatment seeking related to the abuse. Specifically, those who had received treatment for abuse were significantly more distressed than victims who had not received treatment. Implications of these findings and directions for future research are discussed.
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Janine M. Schroeder
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CHAPTER I

INTRODUCTION

Prevalence of Child Sexual Abuse and Adult Sexual Assault

Research examining the phenomenon of interpersonal violence, particularly sexual victimization, against women and children demonstrates that such experiences are not uncommon. Estimates of the prevalence of childhood sexual abuse (CSA) range from 15% to 33% in the general female population (for review, see Kendall-Tackett, Williams, & Finkelhor, 1993). Based on available research (e.g., Peters, Wyatt, & Finkelhor, 1986; Russell, 1983; Wyatt, 1985), Urquiza and Goodlin-Jones (1994) concluded approximately one third to over half of the women in the United States have been exposed to inappropriate sexual contact sometime during their childhood. Rates are even higher within various clinical populations, with 35% to 75% of female clients reporting a history of CSA (e.g., Briere & Runtz, 1988; Briere & Zaidi, 1989; Bryer, Nelson, Miller, & Krol, 1987; Carlin & Ward, 1992; Chu & Dill, 1990; Harrison, Hoffman, & Edwall, 1989; Jacobson, 1989; Miller, Downs, Gondoli, & Keil, 1987; Palmer, Chaloner, & Oppenheimer, 1992; Rohsenow, Corbett, & Devine, 1988). Although substantial research regarding the prevalence of CSA has been conducted, a great deal of variability in prevalence estimates remains.

The prevalence of rape and other acts of sexual assault among adults has also been the focus of considerable research. Estimates of sexual abuse in adulthood have
ranged from 15% to 22% (Koss & Burkhart, 1989). Sandberg, Matorin, and Lynn (1999) concluded, based on available literature (e.g., Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Russell, 1986; Sorenson, Stein, Siegel, Golding, & Burnam, 1987), between 20% and 40% of all women will experience some form of sexual assault during their lifetime. Currently, the rate of adult sexual assault has not been firmly established in the empirical literature.

Short- and Long-Term Effects of Child Sexual Abuse and Adult Sexual Assault

Despite disagreement about the actual prevalence rates of CSA and adult sexual victimization (ASV), research has identified various short- and long-term consequences associated with such experiences. Deleterious short-term effects of CSA include: fear, anxiety, depression, anger and hostility, aggression, and sexually inappropriate behavior (Browne & Finkelhor, 1986). Psychological sequelae persisting in adulthood include: general psychological distress, depression, self-destructive behavior, suicide, fear and distrust of others, feelings of social isolation and stigma, poor self-esteem, anxiety, posttraumatic stress disorder (PTSD), somatization, feelings of hostility, substance abuse, difficulties in social and interpersonal functioning, and poor sexual adjustment and dysfunction (Briere, 1992; Browne & Finkelhor, 1986; Hoier et al., 1992; Lipovsky & Kilpatrick, 1992; Polusny & Follette, 1995).

Sexual victimization in adulthood can also result in serious mental health consequences for victims. Research indicates that ASV is associated with the

Revictimization

*Child Sexual Abuse and Revictimization in Adulthood*

One of the most disturbing long-term effects associated with experiences of CSA is an increased risk of revictimization (Briere, 1992; Messman-Moore, Long, & Siegfried, 2000). Victimologists have long recognized that victimization is not randomly distributed in the population. As suggested by Mandoki and Burkhart (1989), “victimization appears to precede, predict, and perhaps produce further victimization” (p. 179). Several empirical studies (for review, see Browne & Finkelhor, 1986; Messman & Long, 1996; Polusny & Follette, 1995) in the literature have supported the hypothesis that women who were sexually victimized as children demonstrate an apparent greater vulnerability to be revictimized later in life.

Representative studies will be briefly reviewed.

*College samples.* Fromuth’s (1983) survey of 482 college women demonstrated women with a history of CSA were significantly more likely to later
experience rape compared to childhood nonvictims. Victims were also significantly more likely to have subsequent nonconsensual sexual experiences. Participants not being “blind” to the purpose of the study and an unclear method of assessment of adult rape and other nonconsensual experiences limited the study. Similarly, in a sample of 586 college women, Alexander and Lupfer (1987) found CSA victims were significantly more likely to subsequently be sexually assaulted than nonvictims. The study was limited in: an imprecise/qualitative method of CSA assessment, no report of the manner in which adult victimization was assessed, and not providing the age criterion used to determine child versus adult experiences.

Koss and Dinero (1989) found evidence of revictimization in a national sample of 2,723 college women. Among adult attempted or completed rape victims \( N = 685 \), 66% reported childhood sexual experiences (including contact and noncontact), with 13% having experienced attempted or completed sexual intercourse during childhood. Comparatively, only 20% \( N = 1,183 \) of nonvictims reported childhood sexual experiences, with 3% having experienced attempted or completed intercourse during childhood. However, the authors did not indicate whether the results were statistically significant.

Results of Stevenson and Gajarsky’s (1991) study found 72% of female victims of CSA and 65% of males were revictimized as adults, which was significantly different than childhood nonvictims. Gidycz, Coble, Latham, and Layman (1993), conducted a prospective analysis with 857 college women, in an effort to overcome retrospective investigations. Results of Gidycz et al.’s (1993) path analysis revealed
that a sexual victimization experience early in life is a risk factor for subsequent revictimization. Compared to childhood nonvictims: women who had been victimized during childhood were significantly more likely to be revictimized during adolescence, those victimized during childhood were significantly more likely to be revictimized as adults, and those revictimized during adolescence had a significantly higher likelihood of being revictimized in adulthood. Similarly, Mayall and Gold (1995) found a significant relationship between contact forms of CSA and subsequent adult victimization, whereas noncontact experiences were not significant.

Urquiza and Goodlin-Jones (1994) found a highly significant relationship between CSA and subsequent rape in adulthood in a multiethnic sample. Women with a history of CSA were three times as likely to be raped in adulthood than childhood nonvictims. Although the majority of studies utilizing college samples demonstrate that revictimization is associated with CSA, Mandoki and Burkhart (1989) failed to find evidence of revictimization. Mandoki and Burkhart explained the nonsignificant finding stating that an analysis of the base rates of victimization revealed that being victimized as a child and in adulthood occurred at a frequency predicted by the joint probability of the base rates. The majority of studies have found supporting evidence for the phenomenon of revictimization; however, college samples may not be entirely representative of the general population so it is important to examine additional populations.

*Clinical samples.* deYoung (1982) found evidence that victims may have an increased likelihood of being revictimized in adulthood, as 29% ($N = 14$) of their 48
paternal-incest victims had been revictimized. In a sample of 98 female inpatients, Chu and Dill (1990) found CSA doubled the risk of both concurrent physical abuse (2.36:1) and sexual abuse (2.20:1) in adulthood. Cloitre, Tardiff, Marzuk, Leon, and Portera (1996) found evidence of revictimization in 409 female inpatients; specifically, CSA victims were 3.1 times more likely to have experienced an adult assault than childhood nonvictims.

Shields and Hanneke (1988) found that victims of marital rape were more likely than nonvictims and physically battered only victims, to have had sexual contact with a family member during childhood. Fifty percent of the “raped and battered” victims had experienced incestuous CSA, compared to 33% of the “battered only” and 22% of nonvictims. Shields and Hanneke concluded, “it appears that a particular context of victimization (the family), as well as a particular type of victimization (sexual) is likely to be repeated in later victimization” (p. 265).

Despite compelling evidence in the clinical samples that revictimization is strongly associated with CSA, Briere and Runtz (1987) did not find a significant association between a history of CSA and subsequent rape in adulthood. Briere and Runtz failed to provide information on the method of assessing adult rape, but it appears they may have investigated completed rape only. It remains unclear whether this is an adequate representation of the phenomenon of revictimization, as investigating completed rape only limits the ability to detect other forms of victimization in adulthood. In addition to evidence of the phenomenon of
revictimization found in college and clinical samples, associations between CSA and subsequent revictimization have been identified in community samples.

Community samples. Wyatt, Guthrie, and Notgrass (1992) found that 40% ($N = 65$) of CSA victims were revictimized in adulthood. Among women who reported contact abuse before the age of 18, almost half (44%) experienced either contact or noncontact abuse in adulthood, and 30% reported contact abuse experiences only, since age 18. Wyatt et al. (1992) demonstrated that CSA victims were 2.4 times more likely to be revictimized as adults than nonvictims. In a sample of 259 women, Wind and Silvern (1992) found that CSA victims had significantly more negative adult experiences (e.g., sexual assault, physical assault, force used in adult relationships) compared to nonvictims. In a sample of 930 women, Russell (1986) demonstrated that 65% of women abused by family members and 61% of women with a history of childhood extrafamilial abuse were victims of rape or attempted rape (excluding incestuous rape) after age 14, compared to only 35% of childhood nonvictims.

In a community and clinical sample, Gorcey, Santiago, and McCall-Perez (1986) found that 37% of CSA victims were later raped as teenagers or adults. Although results were not reported from the control group nor was a test for significance included, the authors indicated this to be a significant number of women experiencing multiple incidents of sexual victimization. Despite the majority of studies utilizing community samples demonstrating that revictimization is associated with CSA, Jackson, Calhoun, Amick, Maddever, and Habif's (1990) examination of the
prevalence of "traumatic experiences" in adulthood did not reveal significant
differences in rates of victimization between victims and nonvictims. It is unlikely that
Jackson et al.'s (1990) study is representative of the phenomenon of revictimization
due to methodology limitations; specifically, "traumatic experiences" was not clearly
defined and it is unclear whether adult sexual assault was even directly investigated.

**Conclusion.** Substantial support for the association between CSA and
subsequent revictimization exists. This association is demonstrated with various types
of samples, each with unique strengths and limitations. College samples are limited
by: the young age of the participants that allows little time for revictimization to
occur, college women tend to be of a higher socioeconomic status compared to those
not attending college, and women attending college must be relatively well-adjusted
to function adequately in that environment.

Clinical samples can be limited by small sample sizes, a lack of standard
statistical analyses, and participants exhibiting greater levels of distress and pathology
compared to women in non-clinical samples. Community samples suffer limitations as
well (e.g., demographics not representative of the population as a whole). Limitations
of existing studies often limit generalization of findings; thus, there remains a need for
additional studies investigating the phenomenon of revictimization, particularly among
community samples.
Researchers have demonstrated that victims of ASV tend to be at increased risk of experiencing subsequent victimization, compared to individuals without an ASV history. For example, Gidycz, Hanson, and Layman (1995), in a prospective investigation where college women were re-evaluated at 2, 5-6, and 9 months after the initial assessment, found a woman's chances of being victimized were dependent upon victimization in the preceding time period. Women with a history of victimization were 1.5-2 times more likely to be victimized during their first quarter of participation, compared to women with no victimization history; women victimized during their initial quarter of participation were approximately 3 times as likely as those not victimized during that time to be revictimized during their second quarter of participation; and among the smaller subset of data available, those victimized during the second quarter were approximately 20 times as likely as those not victimized during that time to be revictimized during their third quarter of participation. Moreover, chances of being victimized in one time period increased with greater severity of victimization in the preceding time period.

Miller et al. (1978) interviewed 341 victims of sexual assault presenting at a rape crisis center, matched data on multiple and first-time rape victims, then compared both groups to general population statistics for the metropolitan area. Results indicated significant differences between multiple and first-time victims, such that 18% (N = 15) of the repeat victims had incest histories compared to only 4% (N = 11) of first-time victims. Additionally, significantly more of the multiple-incident
victims had previously sought psychiatric assistance compared to single-incident victims, 48% and 21%, respectively. Despite 24% of the sample being recidivist victims, Miller and colleagues suggested that prevalence rates from crisis settings may under represent true rates, as crisis settings are not necessarily conducive to collection of sensitive historical data and many victims do not seek professional help.

Similarly, Ellis, Atkeson, and Calhoun (1982) found 21% ($N=25$) of their sample of women presenting at a rape crisis center were victims of multiple rapes and multiple victims were more dysfunctional than victims who had been assaulted one time. Sorenson, Siegel, Golding, and Stein's (1991) investigation revealed that two thirds of the 433 respondents were multiple victims, with 3.2 being the average number of incidents per person. Marhoefer-Dvorak et al. (1988) found 31% ($N=16$) of participants in their sample were victims of multiple rapes and the average number of incidents per person was 3.9.

**Conclusion.** Research examining the prevalence of sexual victimization indicates that CSA and adult sexual assault are common experiences for many women in our society. Evidence suggests those experiences place them at increased risk for subsequent victimization. Despite support in the current literature for the phenomenon of revictimization, further research is necessary to clarify ambiguous findings, to confirm existing results, and to address remaining unanswered hypotheses.
Effects of Revictimization

In a review of the psychological impact of sexual assault, Hanson (1990) proposed that traumatic experiences (e.g., rape) and life stresses tend to be cumulative, such that people who have experienced many prior stresses tend to cope less effectively than people who have had few other stresses. It is well recognized in the literature that victims of CSA and ASV often experience a myriad of psychological problems in the aftermath of the victimization (e.g., Gidycz et al., 1993; Kilpatrick et al., 1987; Sappington, Pharr, Tunstall, & Rickert, 1997). Roth, Wayland, and Woolsey (1990) reported 43% ($N = 30$) of victims in their sample met criteria for a psychiatric case, compared to only 24.4% ($N = 128$) of nonvictims. It is particularly disturbing that victims of multiple assaults may experience an even further intensified effect.

Researchers (e.g., Ellis et al., 1982; Murphy et al., 1988; Ruch, Amedeo, Leon, & Gartrell, 1991) have found that multiple victimization experiences have a greater detrimental effect on victims' functioning compared to single incidents. In an examination of the cumulative impact of multiple victimization experiences on psychological functioning, Follette, Polusny, Bechtle, and Naugle (1996) found women with three forms of abuse (CSA, adult physical abuse, ASV) were more distressed than women with two forms of abuse, those with two forms were more distressed than women with one form, and women with one form of abuse were more distressed than nonvictims. Follette et al. (1996) concluded "it does not seem to be the case that women habituate to repeated violent experiences, but rather that they
will show increasing levels of symptoms” (p. 33), indicating a cumulative trauma effect. Similarly, Gidycz et al. (1993) found evidence of a cumulative trauma effect, as CSA victims revictimized as adults scored higher on depression and anxiety assessment measures, compared to CSA only victims and nonvictims. Subsequently, CSA victims scored higher than nonvictims.

Messman-Moore et al. (2000) reported CSA was associated with greater vulnerability to victimization in adulthood and they concluded those experiences have a cumulative trauma effect. Specifically, revictimized women and multiple adult victims reported more symptomatology than women with one form of adult assault and nonvictims. Revictimized women reported more somatic complaints and multiple adult assault victims were more depressed, than CSA only victims.

Results revealed that victims of CSA only experienced greater psychological problems compared to nonvictims. Additionally, CSA only victims experienced more anxiety and PTSD-related symptomatology than victims of adult assault only. Messman-Moore et al. (2000) concluded the failure to find differences between levels of distress of revictimized women (CSA and adult assault) and those with multiple adult assaults is consistent with the hypothesis that negative effects are predominantly associated with a cumulative trauma effect, rather than with revictimization from childhood to adulthood specifically. Contrary to the majority of findings in the literature, Sorenson et al. (1991) failed to find significant differences in psychological adjustment between single- and multiple-incident victims. Further research is necessary to test the accuracy of Sorenson et al.’s findings, which may have been the
result of utilizing atypical methodology (e.g., using a broad definition of sexual assault which placed victims of both contact and noncontact experiences in the same group).

**Conclusion.** Results of current research suggest that the phenomenon of revictimization is associated with increased psychological distress among victims. It is imperative that researchers continue the monumental task of understanding the experiences of victims exposed to single and multiple assaults so preventive efforts and interventions can be implemented.

**Characteristics of Abuse/Assault**

Researchers continue to examine the impact of characteristics related to the abuse situation (e.g., duration, frequency) when conducting studies in the area of sexual victimization, as there is not complete consensus in the literature. Groth (1978) proposed that the greatest trauma occurs in sexual abuse with the following characteristics: (a) continues for a longer period of time, (b) occurs with a more closely related perpetrator, (c) involves penetration, and (d) aggression is present. MacFarlane (1978) concluded that greater trauma occurs when: (a) child participation to some degree is present, (b) parental reaction to disclosure of the abuse is unsupportive, and (c) a child is older and more aware of cultural taboos that have been violated. Wind and Silvern (1992) found the characteristics of CSA that were associated with diverse symptomatology in adulthood included: frequency and duration of the abuse, the emotional significance of the perpetrator, the perpetrator
being a father figure, severity of the abusive acts, and whether physical force was used.

Wyatt and Newcomb (1990) identified specific characteristics of the CSA experience that were related to negative effects in adulthood. Long-term negative outcomes of abuse were directly affected by a close relationship to the perpetrator, greater severity of abuse, more immediate negative responses, internal attributions (self-blame), and nondisclosure regarding the sexual abuse. Beitchman et al. (1992), in a review of the long-term effects of CSA, indicated that victimization experiences characterized by a longer duration, involvement with a father figure, sexual penetration, and the use or threat of force might be associated with more negative adult outcomes.

**Conclusion.** Researchers have attempted to identify characteristics of the abuse that are related to psychological adjustment among survivors of sexual victimization. Characteristics of abuse that have been identified as related to more negative psychological outcomes include: (a) greater frequency of abuse, (b) longer duration, (c) more intimate forms of sexual activity (e.g., penetration), (d) age of the victim, (e) gender of the perpetrator (male), (f) age of the offender (older), (g) unsupportive reactions to disclosure of the abuse (particularly from parents), (h) victim being closely related to the perpetrator (a father or father figure) and/or abuse where betrayal is present and trust has been violated, and (i) threat or use of force. Among adult victims, characteristics such as completed rape, older age, a history of adjustment problems, a history of sexual victimization, not receiving treatment, and
lack of social support have been associated with more negative outcomes. Although substantial research has examined the relationship between characteristics of abuse and psychological outcomes (for reviews, see Browne & Finkelhor, 1986; Hanson, 1990; Polusny & Follette, 1995) and many of the characteristics listed above have achieved some empirical support, further research is needed to support current findings and clarify discrepancies in the available literature.

**Coping**

Researchers have begun to focus on variables (e.g., coping strategies survivors employ in an attempt to deal with the aftermath of abuse) mediating psychological adjustment to sexual victimization. Aldwin and Revenson (1987) found a bi-directional relationship between coping and psychological symptoms. Specifically, individuals in poorer mental health and under greater stress used less adaptive coping strategies, such as escapism. Additionally, coping efforts continued to predict current mental health independent of prior symptom levels and degree of stress. Aldwin and Revenson's study, although not specifically focused on coping with sexual victimization, indicated that methods of coping have an impact on mental health.

Burgess and Holmstrom (1979) found coping ability modified victims' response to rape. Researchers (Burgess & Holmstrom, 1979; Koss & Burkhart, 1989) have demonstrated an association between strategies such as dramatization, minimization, rationalization, self-enhancement, and suppression, and victims'
adjustment to rape trauma. Strategies such as self-blame and denial are also negatively associated with victims' adjustment to rape trauma (Janoff-Bulman, 1985; Koss & Burkhart, 1989; Meyer & Taylor, 1986). Johnson and Kenkel's (1991) investigation of factors leading to better or worse adjustment, demonstrated coping strategies of wishful thinking and tension reduction (including healthy and self-destructive activities), lack of maternal support at time of reporting, and appraisals of threat and "holding self back" accounted for 70% of the variance in self-reported distress.

Proulx, Koverola, Fedorowicz, and Kral (1995) found significant differences between single victims, multiple victims, and nonvictims on reported symptomatology and coping strategies. Specifically, the victimized groups were more distressed than nonvictims, the multiple victimization group reported greater use of coping strategies than nonvictims, and both the single and multiple victimization groups indicated greater use of the escapism strategy compared to nonvictimized controls. Regression analyses demonstrated that coping strategies were predictive of distress symptomatology in all three groups and that escapism was the most powerful predictor of distress in each group.

Researchers (Briere, 1989; Browne & Finkelhor, 1986) have reported that part of the behavioral sequelae of sexually traumatized individuals includes avoidant responses (e.g., withdrawal, denial, dissociation). Proulx et al. (1995) reported that generally, the more severe the trauma, the more escapism strategies are employed, and thus severe distress could increase the use of escapism strategies. Proulx and colleagues concluded that avoidance of cognitions and emotions related to the trauma
may preclude the successful resolution of the trauma, resulting in the maintenance of distress and an increased likelihood that additional escapism strategies will be employed.

Results of Leitenberg, Greenwald, and Cado's (1992) investigation of coping strategies women utilize to deal with the aftermath of CSA, revealed that from the time the abuse ended until the study, denial and emotional suppression were the most commonly utilized coping strategies. Regression analyses indicated avoidant/emotional suppressing coping strategies were most frequently utilized and rated as helpful by participants; however, those strategies were in fact associated with poorer adult psychological adjustment. Leitenberg et al.'s (1992) study was not specifically designed to examine whether strategies victims employed to cope with abuse reflected a general coping style or was specific to CSA experiences.

Coffey, Leitenberg, Henning, Turner, and Bennett (1996), in an attempt to extend Leitenberg et al.'s (1992) findings, examined the relation between coping strategies adults use to deal with a history of CSA and current psychological adjustment in a community sample of 192 women. Regression analyses indicated disengagement methods of coping with sexual abuse accounted for unique variance in general psychological distress, even after controlling for characteristics of abuse and methods of coping with other stressors. Disengagement strategies were utilized more often to deal with CSA than other stressful events and engagement strategies were used more frequently to cope with other stressors than to cope with abuse. Coffey et al.'s (1996) study was limited by not counterbalancing the order of completion of
the coping assessment measure; thus, it was impossible to rule out the potential that disengagement strategies were endorsed more often in response to sexual abuse, simply because it was responded to first. Confirmation of Coffey et al.'s findings is necessary, although they are consistent with previous findings that avoidant methods of coping are associated with higher levels of psychological distress in CSA survivors (e.g., Johnson & Kenkel, 1991; Leitenberg et al., 1992) and survivors of adult sexual assault (e.g., Meyer & Taylor, 1986; Wirtz & Harrell, 1987).

Conclusion. Further research is necessary to elucidate the link between coping with sexual victimization and psychological adjustment. Generally, research indicates that avoidant forms of coping may be particularly detrimental to victims' adjustment. Although researchers have documented a relationship between methods of coping and subsequent psychological adjustment, future research is needed to improve on limitations of existing studies.

Experiential Avoidance

Avoidant forms of coping referred to in the literature in various terms (e.g., avoidance, emotional avoidance, experiential avoidance, disengagement) have been linked to poorer psychological adjustment. Although research has documented a relationship to traumatic events, particularly sexual victimization, and psychological adjustment/outcomes, there remains a need for explanatory models for understanding this link. Hayes, Wilson, Gifford, Follette, and Strosahl's (1996) theory of experiential avoidance may provide a helpful framework for understanding the link between
trauma exposure (e.g., sexual victimization) and subsequent psychological adjustment. Hayes et al. (1996) define experiential avoidance as the:

phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them. (p. 1154)

While coping strategies involving attempts to avoid or suppress negative emotions or thoughts may provide relief in the short term, and therefore are maintained, they often are associated with a negative clinical outcome (Hayes & Gifford, 1997).

First, experiential avoidance may actually increase the avoided private events thereby exacerbating problems associated with them. Second, some avoidance methods (e.g., substance abuse, social withdrawal, dissociation) may appear to be successful in the short-term but actually cause more problems (e.g., psychological, physical, legal, social) in the long run. Third, private reactions may become linked to pathological forms of avoidance instead of serving as useful information about one’s own history. Fourth, avoiding private experiential data may inhibit properly informed behavioral choices due to lack of personal data.

Researchers (e.g., Briere, 1992; Briere & Runtz, 1991, 1993; Follette, 1994; Root, 1989) have conceptualized many of the long-term correlates of sexual abuse as forms of avoidance or tension-reducing behaviors. In a discussion of Hayes’ theory of experiential avoidance and CSA, Follette (1994) and Polusny and Follette (1995) suggested that individuals with a history of sexual abuse may utilize behavioral strategies such as dissociation, self-mutilation, and substance abuse in an attempt to avoid making contact with abuse-related affect and memories. The use of these
avoidance behaviors may be negatively reinforced by the reduction or suppression of negative abuse-related affect (Polusny & Follette, 1995). Empirical evidence supports the link between trauma exposure, experiential avoidance, and poor clinical outcomes.

Leitenberg et al. (1992) found that denial and emotional suppression had significantly higher frequency ratings compared to all other methods of coping. Although participants reported that social support, avoidance, emotional suppression, and denial were the most helpful methods of coping; the use of denial and avoidance coping was significantly associated with greater psychological distress. Research in the area of criminal victimization (including rape) has found avoidant coping strategies to be associated with greater distress (Wirtz & Harrell, 1987).

Some researchers even suggest that addictive behaviors in individuals exposed to trauma may be related to avoidance of memories associated with the traumatic event (Briere & Runtz, 1993). For example, consuming alcohol may allow the trauma survivor to successfully avoid memories, feelings, and thoughts related to the traumatic event. Researchers (for review, see Polusny & Follette, 1995) have conceptualized dissociation, binge-purge eating, somatization, compulsive sexual behavior, and self-mutilation and suicide attempts as behavioral forms of emotional avoidance. Although many times those methods of experiential avoidance are viewed as helpful by the trauma survivor, they most often result in less successful adjustment.

In addition to experiential or emotional avoidant coping strategies being linked to poorer psychological functioning, researchers (Polusny & Follette, 1995) have proposed that utilizing experiential avoidant coping strategies may lead to behaviors
that result in more proximal stressors. They suggested that experiencing sexual assault or remaining in physically abusive relationships are two psychosocial stressors that are associated with emotional avoidance. Polusny and Follette reported that adult survivors of sexual victimization might experience an increased vulnerability to revictimization partially due to engaging in chronic dissociative coping behaviors. Herman (1992) proposed that dissociation might result in survivors ignoring or minimizing cues in potentially dangerous situations. Simons and Whitbeck (1991) proposed that previous sexual abuse indirectly increases the probability of further (adult) victimization through an increased likelihood that survivors will participate in a lifestyle that includes other high-risk behaviors (e.g., substance abuse).

**Conclusion.** Empirical evidence suggests that coping styles employed by sexual abuse survivors are related to subsequent psychological adjustment. Experiential/emotional avoidant forms of coping have been found to be particularly deleterious to a trauma survivors’ psychological adjustment and have also been associated with increased risk for subsequent revictimization. Further research is necessary to confirm the relationship between potentially detrimental coping methods (e.g., avoidant) as well as beneficial strategies, and psychological outcomes among trauma survivors.

**Critique of the Extant Literature**

The available studies reviewed here provide evidence for important links between childhood sexual victimization, adult sexual victimization, revictimization,
coping strategies, and psychological adjustment; however, additional research is clearly warranted. Evidence exists that indicates women with CSA histories, as well as those with ASV histories, have a high probability of being revictimized as adults. The phenomenon of revictimization is supported in the literature; however, researchers focusing on the psychological adjustment of single- versus multiple-incident victims have found conflicting evidence. Gidycz et al. (1993) stated that future research is needed to illustrate the recovery process and assess factors that assist victims of single and multiple incidents of sexual victimization in coping with those experiences.

Messman-Moore et al. (2000) provided an explanation for studies that do not find differences in psychological functioning between victims of adult abuse only and nonvictims. Specifically, those studies may actually include women who have been victimized during childhood. It is noteworthy that sexual abuse researchers have not routinely investigated multiple childhood victimization experiences in the histories of sexually abused participants (Briere & Runtz, 1990). With less than adequate assessment of victimization over the course of an individual's lifetime, individuals who have been victimized as children may be included in the nonvictim control group, which is likely to render the results inaccurate. Thus, additional research is clearly needed to elucidate differences in psychological adjustment among women with single victimization experiences in childhood or adulthood, multiple victimization experiences in childhood or adulthood, and victims of CSA who have been revictimized in adulthood.
The majority of existing research supports the link between revictimization and increased psychological distress. Research demonstrating that CSA victims are particularly vulnerable to revictimization later in life is especially alarming, as the experience of revictimization itself may compound or magnify the effects of CSA (Messman & Long, 1996). Systematic research is lacking, as many studies providing information were not specifically designed to investigate revictimization, rather the information is often a side-note to other findings (Messman & Long, 1996). Thus, well-controlled studies that systematically investigate cumulative effects are needed, as the cumulative impact of trauma across the lifespan has not been sufficiently addressed.

Researchers have attempted to identify characteristics of abuse that are associated with psychological adjustment. Many abuse-specific characteristics have achieved strong empirical support with regard to the impact on psychological distress; however, conflictual findings exist, suggesting the need for more methodologically sound studies that specifically examine abuse characteristics. Coping strategies employed by sexual abuse survivors have also been associated with psychological adjustment, with avoidant forms found to be particularly detrimental to adjustment.

Avoidant coping strategies may also be linked to increased risk for revictimization. Further research is necessary to confirm the relationship between hypothesized detrimental coping strategies (e.g., experiential/emotional avoidant) as well as more beneficial strategies, and psychological outcomes among trauma survivors. Leitenberg et al. (1992) identified a need for research to determine if the
link between strategies of coping with sexual abuse and psychological adjustment is a specific association or a subset of a link between a general coping style and psychological adjustment.

Many studies examining the phenomenon of revictimization possess a number of design and measurement problems that limit the utility and generalization of the findings. Most investigations have been conducted with samples (e.g., college students) that are not representative of the population as a whole. Considerable variability exists with regard to the ages at which childhood and adulthood experiences are separated, as well as how they are defined and assessed. Additionally, Browne and Finkelhor (1986) stressed the importance of including control groups in future investigations of sexual victimization, which are lacking in many studies existing in this area.

Roodman and Clum (2001) stated, “absent a universally accepted definition for what constitutes child-to-adult revictimization, the field is vulnerable to methodologically based variance in the conclusions.” Systematic differences between studies that potentially account for observed differences in rates of revictimization include: sample type (e.g., college), differences in age between samples (e.g., studies utilizing college students often include relatively young participants who have had less time to experience revictimization), variation in the manner information is gathered, (e.g., providing a list of possible behaviors versus asking a single question about whether abuse has occurred), age chosen to delineate child from adult abuse, differences between the number of years between the perpetrator and victim before
abuse is considered to have occurred, and differences in how CSA and ASV are defined. Briere (1992) identified the need for future sexual abuse research that is characterized by “more tightly controlled and methodologically sophisticated studies that seek to disentangle the antecedents, correlates, and impacts of sexual abuse” (p. 202).

Overview of the Present Study

The present study examined the relationship between childhood sexual victimization, adult sexual victimization, revictimization, characteristics of abuse, coping strategies, and psychological adjustment/outcomes. A retrospective design was employed with a community sample. Female participants were recruited from a mailing list, various clinics/organizations, and newspaper advertisements. Participants were asked to complete a battery of the most psychometrically sound self-report measures currently available. Participants were separated into the following groups based on their sexual victimization history: (a) single childhood victims (those with one incident of abuse during childhood), (b) multiple childhood victims (those with more than one incident of abuse during childhood), (c) single adult victims (those with one incident of assault in adulthood), (d) multiple adult victims (those with more than one incident of assault in adulthood), (e) revictimized (those sexually victimized in both childhood and adulthood), and (f) nonvictims.

The present study implemented suggestions provided by Roodman and Clum (2001) in an attempt to overcome limitations of existing research by: (a) utilizing the
most psychometrically sound assessment measures possible, (b) using a sample of community participants to achieve a sample more representative of the general population, (c) analyzing victimization defined in various ways (e.g., contact vs. noncontact) to compare the impact of different definitions on findings, and (d) assessing victimization experiences across the lifespan (i.e., childhood to adulthood). Existing studies (e.g., Leitenberg et al., 1992) investigating methods of coping with sexual victimization have succeeded in expanding the knowledge base in this area; however, limitations (e.g., use of coping assessment measures that are not standardized) hinder conclusions that can be drawn. For example, Coffey et al.’s (1996) conclusions were limited by not counterbalancing the coping assessment measure utilized. Proulx et al. (1995) identified that future studies using coping scales that focus on a specific problem are required to discriminate which strategies are employed to cope with certain problems. The present study was a partial replication of Coffey et al.’s study and was designed to overcome limitations in existing research; accomplished by counterbalancing the coping assessment measures (possessing known psychometric properties) that examine coping strategies employed to deal with the aftermath of victimization versus other stressful life events.

Hypotheses

The present study investigated the following hypotheses:

Hypothesis 1: Individuals with a history of sexual victimization would report greater psychological distress, as evidenced by significantly higher GSI scores, than
individuals with no sexual victimization history. Significant differences related to victimization status and psychological distress were expected, such that revictimized and multiple victimized women would experience greater distress than both women in the single victimization group and nonvictims, and women in the single victimization group would report greater distress than nonvictims.

**Hypothesis 2:** Individuals with a history of sexual victimization would endorse more frequent use of disengagement coping strategies, as measured by higher scores on the disengagement tertiary subscale on the CSI, compared to nonvictims.

**Hypothesis 3:** Individuals with a history of sexual victimization would differ significantly in the use of engagement or disengagement methods of coping in response to sexual abuse/assault versus other stressful life events.

**Hypothesis 4:** Methods of coping (i.e., engagement, disengagement) with CSA would account for significant variance in adult adjustment/psychological distress, as evidenced by significantly higher GSI scores, even after controlling for characteristics of abuse and methods of coping with other stressors.

**Hypothesis 5:** Psychological distress, as evidenced by significantly higher GSI scores, would be predicted by the use of avoidant (disengagement) coping strategies, a history of CSA, characteristics of the abuse, and treatment history related to the abuse.

**Hypothesis 6:** Victims who experienced more severe abuse would exhibit greater psychological distress, as evidenced by significantly higher GSI scores, compared to victims who suffered less severe abuse.
Hypothesis 7: Women who have received professional psychological assistance for sexual abuse/assault related issues would exhibit less psychological distress, as evidenced by significantly lower GSI and IES-R scores, compared to victims who did not receive treatment.
CHAPTER II

METHODS

Participants

A total of 1,646 women, 18 years of age and older, were invited to participate in the current study. Participants were recruited from communities in the Midwestern United States. A community sample more representative of the general population was selected, to overcome limitations of previous research utilizing college students and to allow comparisons to existing studies (e.g., Coffey et al., 1996). Of the women surveyed, 212 returned the materials with 4 not included in the final sample due to incomplete data, resulting in a response rate of 12.9%. Although the response rate was low, it is comparable to existing studies (e.g., Coffey et al.) in the area of sexual victimization.

Demographics

The final sample consisted of 208 female participants. The mean age of the women in this study was 39.73 years ($SD = 12.96$; range = 18-79). Ninety percent of the participants were Caucasian, 4% were African American, 1% were American Indian, 1% were Asian American, 1% were Hispanic/Latino, and 1% were multiracial. The educational background of the women included: 2% did not complete high school, 6% high school diploma or equivalent, 23% some college credit, 10%
technical school or vocational training, 12% associate degree, 29% bachelor degree, 14% master's degree, and 3% doctoral degree.

With regard to current relationship status, 27% of the women reported being single, 4% were engaged, 12% living with a partner, 48% married, 5% were separated or divorced, and 1% were widowed. Regarding current financial status, 3% of the women reported being poor, 18% indicated being somewhat poor/struggling, 75% were medium/comfortable, and 3% perceived themselves as rich. Fifty-six percent of the women who participated had a history of psychological treatment related to various problems. More specifically, 12% of victims indicated they had received treatment for abuse or assault-related issues.

Procedures

Participant recruitment included randomly selecting potential individuals from the Equifax Consumers List by various mailing zip codes in the local area, inviting female employees from various clinics/organizations, and extending invitations through newspaper advertisements. Survey materials were then distributed by mail, either to an individual's residence or place of employment. The assessment packet contained a consent form, assessment measures, an optional future contact form/postcard, a list of mental health resources, and postage paid return envelopes.

Participants were instructed not to include any identifying information on their assessment materials, to protect anonymity. They were assured their responses would remain strictly confidential and were reminded that participation was voluntary so
they were free to discontinue participation at any time. All participants who completed the assessment materials had the opportunity to return the future contact form if they wanted to be eligible for one of six $50 cash prizes. The Western Michigan University Human Subjects Institutional Review Board reviewed and approved this study.

Self-Report Measures

The following assessment measures were utilized in the present study.

**History of Information Form (HIF):** Participants completed a brief form developed by the author to assess demographic information (e.g., age, socioeconomic status) and psychological treatment history.

**Sexual Experiences Survey (SES; Koss, Gidycz, & Wisniewski, 1987):** The SES, originally developed by Koss and Oros (1982), was designed to detect various degrees of sexual victimization and has been widely utilized in the area of rape research. The 10-item self-report instrument utilizes behaviorally specific items and is thought to be capable of identifying “hidden” victims (Koss, 1985) who do not report rape, seek services, or even identify themselves as rape victims. Psychometric properties from a revised version of the original SES include internal consistency reliability of .74 and test-retest reliability of .93 (Koss & Gidycz, 1985).

Regarding veracity of self-reported sexual experiences, Koss and Gidycz (1985) obtained a Pearson correlation of .73 between self-reported level of victimization on the SES and level of victimization based on interviews. Originally the
SES was developed to assess victimization since the age of 14, although variations in age and time periods (e.g., number of incidents over past year/past academic year) have been widely utilized. According to Koss (personal communication, October 10, 2001), the SES is a robust measure that performs in a stable manner despite variations.

The present study utilized the SES to assess adult (occurring after the age of 16) and childhood (occurring before the age of 16) sexual victimization experiences. For the assessment of childhood experiences, the items remained identical to the existing SES items (Koss et al., 1987), with the variation consisting of instructions to respond in relation to experiences that occurred prior to age 16. The SES demonstrated good internal consistency in the current study, with Cronbach alpha coefficients of .87 for the child version and .83 for the adult version.

After completion of each SES version, participants answered a question to determine the number of times she had experienced various acts of victimization by different perpetrators to allow for classification of groups (i.e., single or multiple childhood victims, single or multiple adult victims, revictimized from childhood to adulthood, nonvictim). To investigate the specified hypotheses, CSA (i.e., affirmative responses to questions 1-10 on the SES) was defined as sexual contact ranging from sexual kissing to completed vaginal, oral, or anal intercourse that occurred prior to age 16 by someone 5 years older than the respondent at the time or with an individual of any age if the contact was not desired or involved threats/coercion/physical force. Adult sexual victimization (i.e., affirmative responses on questions 4-10 on the SES)
was defined as unwanted, coercive, and/or forced sexual contact ranging from attempted to completed vaginal, oral, or anal intercourse (including vaginal, oral, and anal penetration by a penis, mouth/tongue, finger, or other object) that occurred after the respondent’s 16th birthday.

*Characteristics of Abuse* (Coffey et al., 1996): To allow for comparison of results, information regarding characteristics of the childhood abuse event(s) such as age when the abuse first occurred, frequency, duration, degree of physical force or threat of physical force employed, relationship of the perpetrator to the respondent, and level of sexual activity was obtained utilizing the same measure Coffey and colleagues employed. If the individual had multiple sexual abuse experiences during childhood, she was instructed to answer questions based on the incident that had the greatest impact on her.

*Coping Strategies Inventory* (CSI; Tobin, Holroyd, & Reynolds, 1984; Tobin, Holroyd, Reynolds, & Wigal, 1989): The CSI, a 72-item self-report questionnaire, examines various methods of coping with a specific stressor. The two factor-analytically derived global (tertiary) scales (Tobin et al., 1989), engagement and disengagement, were utilized in the current study to allow comparison of results to Coffey et al.’s (1996) findings. The 36-item engagement factor reflects an individual’s attempts to actively engage in the management of her stressful person and environmental transactions, with those coping strategies representing an active and ongoing negotiation with the stressful environment. The 36-item disengagement factor reflects coping strategies that disengage the individual from person and
environmental transactions, where feelings are not shared with others, thoughts about situations are avoided, and behaviors that could potentially change the situation are not initiated.

The CSI was chosen due to sound psychometric properties including a hierarchical structure of coping, robust internal consistency, sound test-retest reliability, and demonstrated criterion and construct validity (see Tobin et al., 1984, 1989). Participants in the present study completed the CSI twice, once related to coping strategies they employ to deal with sexual abuse/assault and once regarding how they handled another recent stressful life event (e.g., divorce) of their specification. In the current study, the Cronbach alpha coefficient was .91 for non-abuse stressors and .93 for the CSI related to sexual abuse. To extend Coffey et al.'s (1996) findings, the order of the CSI was counterbalanced to rule out the possibility that certain strategies (e.g., disengagement) were endorsed more frequently in response to sexual abuse simply because it was completed first.

Impact of Event Scale-Revised (IES-R; Weiss & Marmar, 1997): The IES-R is a widely utilized 22-item self-report instrument developed as a means of assessing PTSD symptomatology. The IES-R yields three subscale scores (intrusion, avoidance, hyperarousal) as well as a composite score of the degree of subject distress experienced over the past 7 days in relation to a traumatic event. The IES-R has demonstrated adequate psychometric properties.

Based on the results of two studies, Weiss and Marmar (1997) reported alpha coefficients ranging from .87 to .92 for the Intrusion subscale, .84 to .86 for the
Avoidance subscale, .79 to .90 for the Hyperarousal subscale. In the current study, the Cronbach alpha coefficient was .96. Women in the present study who defined themselves as victims of sexual abuse/assault completed the IES-R with respect to the distress they were experiencing in relation to those experiences.

Brief Symptom Inventory (BSI; Derogatis & Spencer, 1982): The BSI, a 53-item self-report questionnaire, was utilized to assess current psychological distress. Respondents rate their degree of distress over the past 7 days on a 5-point scale (ranging from 0 = “not at all” to 4 = “extremely”). The BSI, utilized with clinical and nonclinical populations, has demonstrated strong convergent and predictive validity (Derogatis & Spencer, 1982).

Of the three global indices available, the Global Severity Index (GSI) was selected because it provides the most sensitive single indicator of distress level by combining information on the total number of symptoms reported and intensity of distress experienced. Good test-retest reliability (.90) has been demonstrated for the GSI (Derogatis & Spencer, 1982) and researchers (Coffey et al., 1996; Leitenberg et al., 1992) have reported high internal consistency (.97 and .96, respectively) of the GSI for their samples. In the current study, the Cronbach alpha coefficient was .97.
CHAPTER III

RESULTS

Traumatic Experiences

With regard to perceived victim status, 27% \( (n = 57) \) considered themselves to be a victim of CSA. According to the definition of CSA specified in the current study (based on responses on the SES-C), 62% \( (n = 129) \) were nonvictims, 7% \( (n = 15) \) were single victims, and 31% \( (n = 64) \) were victims of multiple incidents of abuse. Examination of the victimization categories specified by Koss et al. (1987) revealed: 62% \( (n = 128) \) were nonvictims, 15% \( (n = 31) \) experienced sexual contact, 5% \( (n = 11) \) experienced sexual coercion, 4% \( (n = 9) \) were attempted rape victims, and 14% \( (n = 29) \) were completed rape victims.

Regarding perceived victim status, 24% \( (n = 49) \) considered themselves to be a victim in adulthood. According to the definition of ASV specified in the current study (based on responses from the SES-A), 55% \( (n = 115) \) were nonvictims, 10% \( (n = 20) \) were single victims, and 35% \( (n = 73) \) experienced multiple incidents of abuse. Based on Koss et al.'s (1987) categories of victimization, 49% \( (n = 102) \) were nonvictims, 6% \( (n = 13) \) experienced sexual contact, 17% \( (n = 36) \) were exposed to sexual coercion, 2% \( (n = 4) \) experienced attempted rape, and 26% \( (n = 53) \) were completed rape victims.
Based on a combination of participant report and confirmation of individual responses on the SES-C and SES-A, 44% \((n = 91)\) were nonvictims, 3% \((n = 7)\) were single childhood victims, 8% \((n = 17)\) were multiple childhood victims, 6% \((n = 13)\) were single adult victims, 12% \((n = 25)\) were multiple adult victims, and 26% \((n = 55)\) were revictimized (victim in childhood and adulthood). Thus, 44% \((n = 91)\) of the sample were nonvictims, 10% \((n = 20)\) were single victims, and 46% \((n = 97)\) were victimized multiple times. Victims of CSA reported a variety of characteristics associated with their abuse such as: highest level of sexual activity that occurred, the relationship of the perpetrator to the victim, age at time the abuse first started, number of incidents, duration, and degree of force that was threatened or utilized. The results of client self-reported characteristics of abuse are displayed in Table 1.

**Hypothesis 1**

A one-way between-groups analysis of variance (ANOVA) was performed to explore the impact of sexual victimization history on current psychological distress. The independent variable, victimization status in childhood and/or adulthood, consisted of two levels which included victims and nonvictims. The dependent variable was psychological distress, as measured by the GSI. Preliminary assumption testing was conducted to ensure normality and homogeneity of variance. Results demonstrated that victims \((M = 60.85, SD = 10.25)\) were significantly more distressed than nonvictims \((M = 53.63, SD = 9.32)\), \(F(1, 206) = 27.55, p = .000\).
## Table 1

Characteristics of Childhood Sexual Abuse

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of sexual activity experienced</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>Showing or viewing of genitals</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Kissing or caressing non-genital body parts in a sexual way or being kissed in a sexual manner</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Touching or being touched in genital areas (breasts included)</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Giving or receiving oral sex</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Penetration of vaginal or anal area with finger/other object</td>
<td>14</td>
<td>19</td>
</tr>
<tr>
<td>Attempted vaginal or anal intercourse</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Completed vaginal or anal intercourse</td>
<td>17</td>
<td>23</td>
</tr>
<tr>
<td>Relationship of perpetrator to the victim</td>
<td>83</td>
<td>100</td>
</tr>
<tr>
<td>Father or father figure</td>
<td>16</td>
<td>19</td>
</tr>
<tr>
<td>Mother or mother figure</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other relative (e.g., brother, uncle)</td>
<td>21</td>
<td>25</td>
</tr>
<tr>
<td>A friend or school acquaintance</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Person they knew who was not a relative</td>
<td>31</td>
<td>37</td>
</tr>
<tr>
<td>Stranger</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Age of victim at time abuse started</td>
<td>74</td>
<td>100</td>
</tr>
<tr>
<td>5 years or younger</td>
<td>16</td>
<td>22</td>
</tr>
<tr>
<td>Age 6-10</td>
<td>24</td>
<td>32</td>
</tr>
<tr>
<td>Above age of 10</td>
<td>34</td>
<td>46</td>
</tr>
<tr>
<td>Number of times victims experienced abuse</td>
<td>74</td>
<td>100</td>
</tr>
<tr>
<td>1 time</td>
<td>19</td>
<td>26</td>
</tr>
<tr>
<td>2-3 times</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>4-5 times</td>
<td>9</td>
<td>12</td>
</tr>
<tr>
<td>6-50 times</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Cannot remember/too many to count</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Duration of Abuse</td>
<td>70</td>
<td>100</td>
</tr>
<tr>
<td>1 year or less</td>
<td>37</td>
<td>53</td>
</tr>
<tr>
<td>1-3 years</td>
<td>11</td>
<td>16</td>
</tr>
<tr>
<td>3-5 years</td>
<td>15</td>
<td>21</td>
</tr>
<tr>
<td>5-14 years</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Degree of physical force threatened or utilized</td>
<td>75</td>
<td>100</td>
</tr>
<tr>
<td>No force was present</td>
<td>33</td>
<td>44</td>
</tr>
<tr>
<td>Some force was used</td>
<td>34</td>
<td>45</td>
</tr>
<tr>
<td>Highest level of force was utilized</td>
<td>8</td>
<td>11</td>
</tr>
</tbody>
</table>
To more thoroughly investigate differences between victimization status and distress, a one-way between-groups ANOVA was conducted. The independent variable, victim status in childhood and/or adulthood, consisted of four levels (nonvictims, single victims, multiple victims, revictimized) and the dependent variable was psychological distress. Preliminary assumption testing was conducted to check for normality and homogeneity of variance, with no serious violations revealed. One possible concern identified was nonequivalent groups, as the single victims group was relatively smaller, potentially making it more difficult to detect statistically significant differences between groups.

There was a statistically significant difference at the $p < .05$ level in GSI scores for the four victim groups, $F(3, 204) = 12.70, p = .000$. In addition to reaching statistical significance, the actual difference in mean scores between the groups was substantial. According to Cohen's (1988) classification, the effect size of .16 calculated in the current analysis, using $\eta^2$, is considered a large effect. Initial examination of the results indicated that participants' levels of distress were as hypothesized, where revictimized women were experiencing the most distress, followed by multiple victims, then single victims, with nonvictims being the least distressed.

To test for statistically significant differences in distress between victim status groups, post-hoc comparisons using the Scheffé tests of means (the most cautious method for reducing the risk of Type 1 error) was implemented. Partial support for hypothesis one was evident as results demonstrated that the revictimized group
(M = 63.47, SD = 9.95) and the multiple victims group (M = 59.71, SD = 9.77) were significantly more distressed than the nonvictimized group (M = 53.63, SD = 9.32). Additionally, the revictimized women (M = 63.47, SD = 9.95) were significantly more distressed than women in the single victims group (M = 56.05, SD = 10.31). Although differences in distress level were in the expected direction, the first hypothesis did not achieve complete support, as the differences between the multiple victims and single victims group, and the single victims and nonvictims, did not reach significance. Examination of distress level revealed that the mean score for the revictimized group, only, was in the clinical range (T score ≥ 63).

Hypothesis 2

A one-way between-groups multivariate analysis of variance (MANOVA) was performed to investigate differences in coping strategies utilized by childhood and/or adult victims and nonvictims. The dependent variables were engagement and disengagement methods of coping and the independent variable consisted of victimization status (i.e., victims, nonvictims). Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity. A violation of the equality of variance assumption was revealed for the disengagement variable; thus, a more conservative alpha level was implemented when determining significance for the univariate test.
A statistically significant difference between victims and nonvictims was demonstrated on the linear combination of dependent variables: $F(2, 205) = 3.84, p = .023$; Wilks’ Lambda = .96; partial $\eta^2 = .04$. When results for the dependent variables were considered separately, the only difference to reach statistical significance using a Bonferroni adjusted alpha level of .025, was disengagement coping: $F(1, 206) = 6.99, p = .009$, partial $\eta^2 = .03$. Mean scores indicated that victims reported more frequent use of disengagement coping strategies ($M = 44.90, SD = 26.03$) than nonvictims ($M = 36.07, SD = 20.88$).

To further investigate differences in coping, a one-way MANOVA was conducted utilizing problem focused engagement, emotion focused engagement, problem focused disengagement, and emotion focused disengagement as dependent variables and victim status as the independent variable. Preliminary testing indicated a violation of the equality of variance assumption for the emotion focused disengagement variable, which resulted in a more stringent alpha level being utilized when the univariate test of significance was conducted. Significant differences were revealed between victims and nonvictims on the combined dependent variables: $F(4, 203) = 3.46, p = .009$; Wilks’ Lambda = .94; partial $\eta^2 = .06$.

Comparing results for the dependent variables separately, the only difference to achieve significance using a Bonferroni adjusted alpha level of .01, was emotion focused disengagement coping: $F(1, 206) = 10.47, p = .001$, partial $\eta^2 = .05$. Mean scores demonstrated that victims reported more frequent use of emotion focused
disengagement coping strategies ($M = 19.89, SD = 15.29$) compared to nonvictims ($M = 13.56, SD = 12.17$). Table 2 demonstrates the means and standard deviations for victims and nonvictims.

Table 2
Means and Standard Deviations of Coping Strategies

<table>
<thead>
<tr>
<th>Coping Strategy</th>
<th>Victims</th>
<th>Nonvictims</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Engagement</td>
<td>60.78</td>
<td>25.27</td>
</tr>
<tr>
<td>Disengagement</td>
<td>44.90</td>
<td>26.03</td>
</tr>
<tr>
<td>Problem focused engagement</td>
<td>30.99</td>
<td>13.80</td>
</tr>
<tr>
<td>Emotion focused engagement</td>
<td>29.79</td>
<td>15.80</td>
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<tr>
<td>Problem focused disengagement</td>
<td>25.01</td>
<td>13.39</td>
</tr>
<tr>
<td>Emotion focused disengagement</td>
<td>19.89</td>
<td>15.29</td>
</tr>
</tbody>
</table>

Hypothesis 3

A one-way between-groups MANOVA was conducted to determine if victims (child and/or adult) differed significantly in their use of engagement and disengagement coping strategies in response to sexual abuse/assault versus other types of stressors. The independent variable was type of stressor and the dependent variables consisted of engagement and disengagement coping strategies. Preliminary assumption testing was conducted to check for normality, linearity, univariate and
multivariate outliers, homogeneity of variance-covariance matrices, and multicollinearity, with no serious violations noted. Although coping methods employed to deal with sexual abuse and methods utilized for other types of stressors were positively correlated (engagement, $r = .39, p < .01$; disengagement, $r = .24, p < .05$), MANOVA procedures revealed significant differences between the type of stressor and method of coping strategies utilized, $F(2, 231) = 39.14, p = .000$; Wilks' Lambda = .75; partial $\eta^2 = .25$.

Further investigation demonstrated two significant differences using a Bonferroni adjusted alpha level of .025; specifically, engagement coping, $F(1, 232) = 39.39, p = .000$, partial $\eta^2 = .15$, and disengagement coping, $F(1, 232) = 42.41, p = .000$, partial $\eta^2 = .16$. Mean scores indicated that engagement coping was utilized more frequently in response to non-abuse related stressors ($M = 60.78, SD = 25.27$) compared to abuse ($M = 40.42, SD = 24.36$). Conversely, disengagement coping strategies were utilized more often in response to abuse ($M = 66.23, SD = 24.04$) than non-abuse related stressors ($M = 44.90, SD = 26.03$).

**Hypothesis 4**

To test the hypothesis that there is a relationship between methods of coping with childhood sexual victimization and psychological distress and to compare results with Coffey et al.'s (1996) findings, simultaneous and hierarchical regression analyses were performed. The predictor variables were: (a) characteristics of the abuse experience (age it first occurred, duration, frequency, level of force utilized, the
relationship of the perpetrator to the victim, and level of sexual activity that occurred; (b) engagement and disengagement coping related to the non-abuse stressful event; and (c) engagement and disengagement coping with the sexual abuse/assault. The criterion variable was psychological distress, as measured by GSI scores.

The simultaneous regression analysis demonstrated a significant relationship between characteristics of abuse, methods of coping with non-abuse stressful events, methods of coping with abuse, and psychological distress yielding a sample multiple correlation coefficient of .70, an overall $R^2$ of .49, and an adjusted $R^2$ of .38, $F(10, 48) = 4.57, p = .000$. Thus, approximately 49% of the variance in distress scores was accounted for by the linear combination of predictor variables. Disengagement coping related to the non-abuse stressful event demonstrated the strongest unique contribution to the explanation of variance in distress, when all other variables were controlled for, $\beta = .37$. Two predictors, disengagement coping with the non-abuse event ($pr = .42, F(10, 48) = 3.18, p = .003$) and disengagement coping with sexual abuse ($pr = .39, F(10, 48) = 2.96, p = .005$), accounted for significant unique variance in distress.

A hierarchical regression analysis demonstrated that when characteristics of abuse were entered first into the equation to predict distress, the overall $R^2$ was .138, $F(6, 52) = 1.39, p = .238$. When engagement and disengagement related to the non-abuse stressor were added, the overall $R^2$ increased to .37, $R^2$ change = .24, $F(2, 50) = 9.36, p = .000$. When engagement and disengagement coping related to sexual abuse
abuse were added to the equation, the overall $R^2$ increased to .49, $R^2$ change = .12, 
$F(2, 48) = 5.38, p = .008$.

Methods of coping with the non-abuse event accounted for an additional 24% of the variance in distress scores above and beyond the characteristics of abuse. This percentage increase, related to disengagement coping, was significant ($p < .05$). Methods of coping with the sexual abuse accounted for an additional 12% of the variance in distress scores above and beyond the characteristics of abuse and methods of coping with non-abuse related stressful events. Similar to Coffey et al.'s (1996) findings, this increment was significant ($p < .05$) and is attributed to disengagement coping. A comparison of the current results with Coffey et al.'s findings is presented in Table 3.

Hypothesis 5

Simultaneous multiple regression analyses were utilized to investigate variables that predict current level of psychological distress. The predictor variables included disengagement (avoidant) coping strategies, a history of CSA (single and multiple incidents), characteristics of the abuse experience, and treatment history. The criterion variable was distress, as measured by GSI scores. In the first analysis, treatment history (related to sexual abuse), characteristics of abuse (age, duration, frequency, force), history of victimization, and disengagement coping, were used.

Results were significant, yielding a sample multiple correlation coefficient of .59, an overall $R^2$ of .35, and an adjusted $R^2$ of .23, $F(7, 38) = 2.93, p = .015$. 

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Table 3
Comparison of Current Results With Coffey et al. (1996)

<table>
<thead>
<tr>
<th></th>
<th>Current Study</th>
<th>Coffey et al.</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>$R$</td>
<td>$R^2$</td>
</tr>
<tr>
<td>Simultaneous Multiple Regression</td>
<td></td>
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<tr>
<td>OVERALL</td>
<td>.698</td>
<td>.488</td>
</tr>
<tr>
<td>DISABUSE</td>
<td>--</td>
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<tr>
<td>DISOTHER</td>
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</tr>
<tr>
<td>Hierarchical Multiple Regression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>STEP 1</td>
<td>.371</td>
<td>.138</td>
</tr>
<tr>
<td>STEP 3</td>
<td>.698</td>
<td>.488</td>
</tr>
</tbody>
</table>

*Note. DISABUSE = disengagement coping with sexual abuse predictor; DISOTHER = disengagement coping with non-abuse event predictor; STEP 1 = characteristics of abuse; STEP 2 = coping with non-abuse event; STEP 3 = coping with sexual abuse.

Approximately 35% of the variance in distress scores was accounted for by the linear combination of predictor variables. Disengagement coping made the largest unique contribution, $\beta = .52$, and was the only variable to provide a statistically significant contribution to the prediction of distress, $F(7, 38) = 3.71, p = .001$. A second analysis examining treatment history (related to sexual abuse), characteristics of abuse (level of sexual activity, relationship of perpetrator to the victim), history of victimization, and disengagement coping, was also significant, $R = .55$, $R^2 = .30$, adjusted $R^2 = .21$, $F(5, 42) = 3.55, p = .009$. This model explained 30% of the variance in distress and
disengagement coping, which made the strongest unique contribution (β = .49), was the only variable to make a statistically significant contribution to the prediction of distress, $F(5, 42) = 3.30, p = .002$.

Compared to the first analysis, results of a simultaneous regression examining general treatment history (not specifically targeting abuse), characteristics of abuse (age, duration, frequency, force), a history of victimization, and disengagement coping demonstrated significance, $R = .62, R^2 = .38$, adjusted $R^2 = .31, F(7, 58) = 5.10, p = .000$. This model explained 38% of the variance in distress, disengagement coping made the strongest unique contribution (β = .52) and was the only variable to make a statistically significant unique contribution to the prediction of distress, $F(7, 58) = 4.85, p = .000$. Compared to the second analysis, results of a simultaneous regression investigating general treatment history (not specifically targeting abuse), characteristics of abuse (level of sexual activity, relationship of perpetrator to the victim), history of victimization, and disengagement coping indicated significance, $R = .59, R^2 = .35$, adjusted $R^2 = .30, F(5, 65) = 6.94, p = .000$. This model explained 35% of the variance in distress, disengagement coping made the strongest unique contribution (β = .53), and both disengagement coping and a general treatment history made statistically significant contributions to the prediction of distress, $F(5, 65) = 5.06, p = .000$ and $F(5, 65) = 2.33, p = .023$, respectively. A summary of the simultaneous multiple regression models are presented in Table 4.
Table 4
Summary of Simultaneous Multiple Regression Models for Prediction of Distress

| Analysis | R    | R²   | Adj R² | F     | p   | R    | R²   | Adj R² | F     | p   |
|----------|------|------|--------|-------|-----|------|------|--------|-------|-----|-----|
| Analysis 1 | .592 | .350 | .231   | 2.93  | .015| .617 | .381 | .307   | 5.10  | .000|     |
| Analysis 2 | .545 | .297 | .214   | 3.55  | .009| .590 | .348 | .298   | 6.94  | .000|     |

Note. Analysis 1 = Characteristics of abuse included age, duration, frequency, and force; Analysis 2 = Characteristics of abuse included level of sexual activity and relationship to the perpetrator.

Hypothesis 6

Independent-samples t tests were conducted to compare the current distress levels between victims of CSA who experienced more severe abuse and those who suffered less severe abuse. Comparing distress levels for child sexual abuse victims whose abuse began at younger ages versus older ages revealed no significant difference in scores for the younger group (M = 62.30, SD = 9.96) and the older group (M = 63.08, SD = 10.78), t(53) = -.28, p = .782. The magnitude of the differences in the means was very small (η² = .001). No significant difference in distress level was demonstrated for victims who experienced abuse over a shorter period of time (M = 61.67, SD = 10.60) compared to an extended period of time (M = 62.95, SD = 11.52), t(47) = -.41, p = .686. The degree of the differences in the means was very small (η² = .003).

No significant difference in distress level was indicated for victims who experienced a lower number of incidents (M = 59.88, SD = 10.71) compared to those...
with a higher number of incidents \((M = 62.64, SD = 10.97), t(48) = -0.90, p = .373\).

The extent of the differences in the means was small \((\eta^2 = .017)\). A significant difference in distress was revealed for victims who endured a higher level of force \((M = 66.20, SD = 9.84)\) compared to those who experienced a lower degree of force \((M = 58.29, SD = 10.29), t(54) = -2.92, p = .005\). The magnitude of the differences in the means was large \((\eta^2 = .136)\).

No significant difference in distress was demonstrated for individuals who were victimized by a perpetrator with a higher level of relationship closeness, specifically a parent or parent figure \((M = 60.93, SD = 11.61)\), versus those with a more distant relationship \((M = 61.83, SD = 10.63), t(72) = .29, p = .775\). The size of the differences in the means was very small \((\eta^2 = .001)\). No significant difference in distress was indicated for victims who experienced a higher level of sexual activity \((M = 62.94, SD = 10.73)\) compared to those who experienced a lower degree of sexual activity \((M = 58.52, SD = 10.54), t(71) = -1.64, p = .105\). The magnitude of the differences in the means approximated a moderate effect \((\eta^2 = .037)\).

**Hypothesis 7**

One-way between-groups MANOVAs were performed to investigate differences in current distress level between victims (child and/or adult) who had received treatment versus those who had not received treatment. Preliminary assumption testing was conducted to check for normality, linearity, univariate and multivariate outliers, homogeneity of variance-covariance matrices, and
multicollinearity, with no violations detected. In the first analysis, the independent variable utilized was treatment history (received treatment for any reason, never received treatment) and the dependent variables consisted of distress level, as measured by the GSI and IES-R. No statistically significant difference was found in terms of distress, between the individuals who had received treatment and those who had never received treatment, $F(2, 79) = 1.50, p = .229$; Wilks' Lambda = .96; partial $\eta^2 = .04$.

In the second analysis, the independent variable consisted of treatment history related to sexual abuse/assault and the dependent variables were distress level, as measured by the GSI and IES-R. Preliminary assumption testing identified a violation of equality of variance for the IES-R, indicating the need for a more conservative alpha for the determination of significance in regard to the univariate test. There was a statistically significant difference between those who had received treatment focused on sexual abuse compared to those who had not received abuse-related treatment, $F(2, 79) = 4.42, p = .015$; Wilks’ Lambda = .90; partial $\eta^2 = .10$.

When the results of the dependent variables were examined separately, significant differences were found for the IES-R, $F(1, 80) = 8.40, p = .005$, partial $\eta^2 = .10$; and the GSI, $F(1, 80) = 5.31, p = .024$, partial $\eta^2 = .06$. An inspection of the mean scores on the IES-R demonstrated that women who had received treatment for abuse ($M = 33.00, SD = 24.57$) were more distressed than those who had not received treatment ($M = 19.30, SD = 17.20$). Similarly, mean scores on the GSI indicated women who had received treatment were currently more distressed.
than those who had not received treatment for abuse 

\((M = 65.52, SD = 10.86)\), than those who had not received treatment for abuse 

\((M = 59.83, SD = 10.05)\).
CHAPTER IV

DISCUSSION

The present study examined the relationship between CSA, ASV, revictimization, characteristics of abuse, coping strategies, and psychological adjustment/outcomes. The first purpose of the study was to examine the relationship between victim status and level of distress, among victims of CSA and/or adult assault and nonvictims. It was hypothesized that victims would be more distressed than nonvictims; specifically, revictimized and multiple victimized women would be more distressed than both women in the single victim group and nonvictims, and women in the single group would report greater distress than nonvictims. The hypothesis was supported in the finding that victims were significantly more distressed than nonvictims.

Upon dividing the victims into the groups described above, a significant difference with a large effect size was found. Mean scores for victim groups indicated that revictimized women were the most distressed followed by multiple victims, single victims, and nonvictims, respectively. Hypothesis 1 received only partial support when post-hoc comparisons were performed. Similar to previous findings (Messman-Moore et al., 2000), hypothesis 1 was supported as revictimized and multiple victims were significantly more distressed than nonvictims, and revictimized women were
more distressed than women in the single group. However, the differences between multiple and single victims, and single and nonvictims did not reach significance.

The current results lend some support to previous findings (e.g., Follette et al., 1996; Gidycz et al., 1993; Hanson, 1990; Messman-Moore et al., 2000) that revictimized and multiple victimized women experience a cumulative trauma effect, resulting in heightened psychological distress. Interestingly, similar to Sorenson et al.'s (1991) findings, multiple victims and single victims did not differ significantly in their levels of distress. It is possible that multiple-incident and single-incident victims do not differ in terms of levels of distress. It may be more probable, particularly if mean scores in distress level associated with single victims in comparison to multiple and nonvictims indicate a nonsignificant trend, that the results were impacted by the relatively small size of the single victim group. Further research needs to confirm the accuracy of this finding.

The second major purpose of the current study was to investigate the frequency of disengagement coping strategies utilized by victims of CSA and/or adult assault versus nonvictims; it was hypothesized that victims would employ more frequent disengagement coping than nonvictims. This hypothesis was supported as victims differed significantly in the frequency with which they used disengagement versus engagement coping. More specifically, victims reported significantly more frequent use of emotion focused disengagement strategies than nonvictims.

The current results are not surprising as Lazarus and Folkman (1984) indicated that emotion focused coping methods are more likely to be used in
situations perceived as uncontrollable and in situations where an individual feels powerless. Moreover, other researchers (e.g., Brown, 1989; Browne & Finkelhor, 1986; Coffey et al., 1996; Leitenberg et al., 1992; Polusny & Follette, 1995; Proulx et al., 1995) have reported similar findings of an association between sexual victimization and avoidant or disengagement type strategies; specifically, that part of the sequelae of sexually traumatized individuals includes avoidant coping responses. The apparent association between sexual victimization is especially problematic due to research (e.g., Aldwin & Revenson, 1987; Coffey et al., 1996; Hayes & Gifford, 1997; Janoff-Bulman, 1985; Johnson & Kenkel, 1991; Koss & Burkhart, 1989; Leitenberg et al., 1992; Meyer & Taylor, 1986; Polusny & Follette, 1995; Proulx et al., 1995) indicating that avoidant coping is associated with more negative psychological outcomes.

The present study found that individuals with a history of victimization use disengagement coping strategies significantly more than nonvictims. Subsequently, as the current study was a partial replication of Coffey et al.'s (1996) research, the third major objective included a more in-depth examination of the type of coping victims of CSA and/or adult assault utilize to deal with the aftermath of abuse or assault compared to other stressful life events. The hypothesis that victims would differ significantly in the use of engagement or disengagement methods of coping in response to abuse versus other stressors was supported with the finding of significant differences between type of stressor and method of coping strategies employed.
More specifically, similar to Coffey et al.'s (1996) findings, victims in the present study utilized engagement strategies more frequently in response to non-abuse stressors and employing disengagement strategies more often in response to abuse or assault. Coffey et al. did not counterbalance the coping assessment measures utilized so they were unable to rule out the possibility that disengagement strategies were endorsed more often in response to sexual abuse simply because it was responded to first. The present study did counterbalance the assessment measures utilized; thus, the present results confirmed Coffey et al.'s findings that disengagement coping strategies are indeed utilized more often to deal with the aftermath of sexual abuse.

In partial replication of Coffey et al.'s (1996) research, the fourth major objective was to test the hypothesis that methods of coping with CSA would account for significant variance in adult psychological adjustment/distress, even after controlling for characteristics of abuse and methods of coping with other stressors. Initial results indicated that characteristics of the abuse experience, methods of coping with non-abuse stressors, and strategies employed to cope with sexual abuse significantly predicted distress level, with 49% of the variance in distress being accounted for by that combination of variables. Additional analyses also supported the hypothesis that methods of coping with sexual abuse would predict psychological distress, even after controlling for characteristics of abuse and methods of coping with non-abuse stressors.

More specifically, methods of coping with abuse accounted for an additional 12% of the variance in distress above and beyond characteristics of abuse and
methods of coping with other types of stressors. Thus, results of the present study confirm Coffey et al.’s (1996) findings. Leitenberg et al. (1992) identified a need for research to determine if the link between strategies of coping with abuse and psychological adjustment is a specific association or merely a subset of a link between a general coping style and adjustment. The current study was designed to examine that issue and found that strategies victims employed to cope with abuse were indeed specific to the abuse experience rather than a reflection of a general coping style.

The fifth major purpose of the present study included testing the hypothesis that psychological distress among victims of CSA would be predicted by: disengagement coping, a history of CSA, characteristics of the abuse experience, and abuse-related treatment history. Initial analyses revealed that disengagement coping, a history of CSA, characteristics of abuse (i.e., age, duration, frequency, force), and a general treatment history were significant predictors of higher levels of psychological distress, with disengagement coping making a statistically significant unique contribution. Results also indicated those same variables, with the exception of characteristics of abuse consisting only of level of sexual activity and relationship of the perpetrator to the victim, were significant predictors of distress, with disengagement coping and treatment history making statistically significant unique contributions to the prediction of distress. When examining treatment related to abuse, analyses indicated disengagement coping, a history of CSA, characteristics of abuse (i.e., age, duration, frequency, force), and treatment history remained significant predictors of increased levels of psychological distress, with disengagement
coping making a statistically significant unique contribution. Results also indicated those same variables, with the exception of characteristics of abuse consisting only of level of sexual activity and relationship of the perpetrator to the victim, remained significant predictors of distress, with disengagement coping making a statistically significant unique contribution to the prediction of distress.

Those results are comparable to previous findings in the literature and in the current study, suggesting that utilization of disengagement coping, having a history of sexual victimization, having experienced more severe abuse, and having a history of seeking treatment, are risk factors for increased psychological distress. Additionally, disengagement or avoidant type coping may be the strongest determining factor in victims’ subsequent psychological adjustment. Having a history of CSA was part of the model that significantly predicted adult psychological distress, demonstrating additional evidence for the cumulative trauma effect found in previous research (e.g., Follette et al., 1996; Gidycz et al., 1993; Hanson, 1990; Messman-Moore et al., 2000). Further examination of the independent predictors described above, particularly characteristics of abuse and treatment history, would be useful in obtaining a more comprehensive understanding the impact of each have on victims’ adjustment. Thus, the remaining two hypotheses investigated characteristics of the abuse experience and treatment history in more detail.

The sixth objective in the current study was to investigate the hypothesis that CSA victims who suffered more severe abuse would be more distressed than those who experienced less severe abuse. Results indicated no significant differences
between victims' levels of distress with regard to age, duration, frequency, relationship of perpetrator to the victim, and level of sexual activity. Those results are somewhat surprising since the majority of existing literature (e.g., Beitchman et al., 1992; Browne & Finkelor, 1986; Groth, 1978; Hanson, 1990; MacFarlane, 1978; Polusny & Follette, 1995; Wind & Silvern, 1992; Wyatt & Newcomb, 1990) has demonstrated characteristics of abuse to be significantly related to psychological outcomes.

There were significant differences between groups with regard to one characteristic of the abuse experience, the degree of force threatened or utilized, which is consistent with the current literature. It is noteworthy that the mean distress scores for victims who experienced a higher degree of force were in the clinical range. Despite significant differences between groups not being revealed for age, duration, frequency, relationship of perpetrator to the victim, and level of sexual activity; it is interesting that many of those characteristics had mean distress level scores in or near the clinical range. Future research is needed to test the accuracy of the present findings, particularly since they are not analogous to previous findings in the literature.

The seventh major purpose of the present study included testing the hypothesis that victims of CSA and/or adult assault who have received treatment would be less distressed than victims who did not receive treatment. Initial results utilizing a general treatment history (not specifically targeted toward abuse) indicated no statistically significant difference in distress levels between victims who had
received treatment and those who did not receive treatment. However, results revealed a statistically significant difference in distress level between those who received treatment for abuse and those who did not receive treatment, with the treatment group exhibiting more distress than the no-treatment group; thus, hypothesis 7 was not supported. Victims' distress levels did not differ significantly when considering treatment-seeking behavior in general; however, differences were apparent when examining treatment seeking related to the abuse, with one possible explanation for the differences in distress levels being that higher levels of distress are actually related to the aftermath of the sexual trauma. Another potential explanation for the findings includes some of the victims who sought (general) treatment and were able to decrease their levels of distress may have actually been seeking treatment for abuse-related symptoms, but were unaware the symptoms were related to the abuse and/or the treatment was not defined as "abuse treatment" despite actually targeting abuse-related issues.

Implications

The findings in the present study have important treatment implications. Specifically, the current study found evidence for a cumulative trauma effect, which has been associated with heightened psychological distress. Since previous traumatic events may potentially exacerbate current symptoms and increase the probability of subsequent victimizations, it would be important that clinicians routinely assess victimization experiences across the lifespan.
The present study found victims of CSA and/or adult sexual assault utilize disengagement coping more frequently in response to abuse and engagement coping in relation to other stressful events. The current study also confirmed that the type of coping strategies (disengagement) victims utilize to cope with the aftermath of sexual victimization are predictive of distress, above and beyond characteristics of the abuse experience and methods of coping with other stressors. The present study confirmed previous findings (e.g., Hayes & Gifford, 1997; Polusny & Follette, 1995) that avoidance coping is associated with more negative psychological outcomes, despite being viewed by the trauma survivor as helpful (e.g., Leinster et al., 1992). Thus, it is imperative that clinicians are aware of the avoidant coping component when treating victims of sexual abuse or assault.

Based on the present findings, it appears important that clinicians assess the strategies victims of abuse or assault are engaging in to cope with the emotional aftermath of the trauma. It is probable that education of the client regarding avoidant coping and outcomes associated with those strategies would be crucial. Finally, clinicians should be prepared to experience resistance from the client, particularly if being asked to engage in active, behavioral strategies, which are polar opposites of the manner in which they are most likely to have been coping.

Limitations

Despite the present study making a significant contribution to the literature, some limitations apply. Since this research was not a prospective study, it is
impossible to determine if the variables investigated here, such as coping, affected psychological adjustment or if adjustment determined type of coping strategies chosen. Due to the present study being retrospective in nature, victim report may have been influenced by the passage of time between incidents of victimization and participation in the current study. Due to the recruitment procedures, these women may not have been representative of the general population as those who were self-selected to participate may be different (e.g., in terms of distress, methods of coping utilized) from those who chose not to participate. Another limitation includes the majority of the sample were Caucasian; thus, caution needs to be utilized when generalizing the results to other racial/ethnic groups.

A limit of the present study included the utilization of self-report measures to collect the data. Implementing a single mode rather than multimodal assessment is not ideal; however, many logistical problems arise when attempting to conduct other types of assessment (e.g., interviews). A limitation of the present study included the mailing procedure utilized to collect data; specifically, the researcher had no control over the independent completion of assessments. However, it is possible that anonymous data collection has a positive impact on the individuals' comfort level, therefore increasing likelihood of participation. Despite limitations in the present study, it is important to note the strengths; for example, utilization of standardized assessment measures and employing a community sample that is more representative of the general population compared to clinical or college samples.
Implications for Future Research

Although the knowledge base in the area of sexual victimization is constantly expanding, a substantial amount of research continues to be necessary. Certain areas, such as differences between single- and multiple-incident victims and the cumulative impact of trauma, are important areas for future focus. Continuing to monitor characteristics of abuse or assault situations to determine the exact nature of their impact on the victim’s psychological adjustment would be beneficial.

Despite the existence of significant research examining the most effective treatment strategies, future research may benefit from shifting the focus to treatment-seeking behavior. The present study found victims who had received treatment were more distressed than those who had not received treatment. It may appear improbable that treatment renders victims more distressed; thus, one potential explanation includes that there are unknown factors regarding victims’ prior level of functioning and/or factors related to determining who presents for treatment. A second potential explanation includes that the victims in the present study were actually more distressed due to the treatment they received. Despite there being effective therapeutic interventions available for the treatment of trauma and PTSD (for review, see Finkelhor & Berliner, 1995; Foa & Meadows, 1997; Price, Hilsenroth, Petretic-Jackson, Bonge, 2001; King et al., 1999), other less effective interventions such as psychological debriefing (e.g., Bisson, 1999) are also utilized with trauma survivors. Finally, the following issues should be taken into consideration in the designing of future research. There remains a need for studies (e.g., prospective) conducted with
community participants (who are more representative of the general population) that utilize multimodal assessments consisting of standardized measures.
REFERENCES


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Appendix A

Human Subjects Institutional Review Board Approval
Date: February 1, 2005

To: Lester Wright, Principal Investigator
    Janine Schroeder, Student Investigator for dissertation

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 04-01-06

This letter will serve as confirmation that the change to your research project "Sexual Victimization: An Examination of Variables Predicting Psychological Adjustment" requested in your memo dated 1/31/2005 has been approved pending review by the full Human Subjects Institutional Review Board at its February 16, 2004 meeting.

The conditions and the duration of this approval are specified in the Policies of Western Michigan University.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: December 15, 2005
Appendix B

Informed Consent Forms
Your name was randomly selected from the Equifax Consumer List to be invited to participate in a research project entitled “Sexual victimization: An examination of variables predicting psychological adjustment.” This research is intended to study how women (18 years of age and older) cope with a variety of stressful or traumatic experiences (e.g., sexual assault, loss of a loved one, relationship difficulties). So you are aware, this research involves exposure to sexually explicit questions, with a considerable focus on past unwanted sexual experiences. This project will serve as Janine M. Schroeder’s dissertation project.

You will be asked to complete a variety of questionnaires in the privacy of your own home and then mail them back (in the envelope provided) to the researchers. These questionnaires may take approximately 45 to 60 minutes to complete.

One potential risk of participation in this project is that you may experience some discomfort in answering the questions about your stressful experiences. If you experience discomfort in answering the questionnaires, you can withdraw from the study at any time without penalty or prejudice. The colored sheet enclosed with this packet includes a list of resources in the community. You may want to contact one or more of these resources if you have concerns or want to explore treatment options. However, you will be responsible for the cost of therapy if you choose to pursue it.

There are no anticipated benefits to those who elect to participate in the present study. However, all participants who complete the assessment materials have the option of being entered into a drawing to be eligible to win one of the various $50 cash prizes. Your participation is important because you would also be helping the field of psychology to expand its knowledge base. Your participation will be beneficial in helping researchers understand how women cope with stressful life experiences, which can assist in the development of treatments.

All of the information collected from you is anonymous and confidential. That means that your name will not appear on any papers on which your responses are recorded. The only place your name will appear is on the optional contact form. The contact form has no code number on it and the Principal Investigator and Student Investigator will separate it from your questionnaires as soon as they receive them so there is no way of identifying you (matching your responses on the questionnaires to your name). The optional contact form will be kept separate from the questionnaires in a locked file in Dr. Wright’s laboratory. All forms containing data will be retained for a minimum of three years in a locked file in the principal investigator’s office.

If you have any questions or concerns about this study, you may contact either Lester W. Wright, Ph.D. at (269) 387-4472 or Janine M. Schroeder, M.A. at (269) 553-0413. You may also contact the chair of the Human Subjects Institutional Review Board at (269) 387-8293 or the Vice President for Research at (269) 387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

Please keep this form for your records instead of returning it with the questionnaires. Returning the questionnaires indicates you have read the purpose and requirements of the study and indicates your consent for use of the answers you supply. If you choose not to participate in the study, please simply discard these materials.
You were selected along with all female employees at your clinic to be invited to participate in a research project entitled "Sexual victimization: An examination of variables predicting psychological adjustment." This research is intended to study how women (18 years of age and older) cope with a variety of stressful or traumatic experiences (e.g., sexual assault, loss of a loved one, relationship difficulties). So you are aware, this research involves exposure to sexually explicit questions, with a considerable focus on past unwanted sexual experiences. This project will serve as Janine M. Schroeder's dissertation project.

You will be asked to complete a variety of questionnaires in the privacy of your own home and then mail them back (in the envelope provided) to the researchers. These questionnaires may take approximately 45 to 60 minutes to complete.

One potential risk of participation in this project is that you may experience some discomfort in answering the questions about your stressful experiences. If you experience discomfort in answering the questionnaires, you can withdraw from the study at any time without penalty or prejudice. The colored sheet enclosed with this packet includes a list of resources in the community. You may want to contact one or more of these resources if you have concerns or want to explore treatment options. However, you will be responsible for the cost of therapy if you choose to pursue it.

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All of the information collected from you is anonymous and confidential. That means that your name will not appear on any papers on which your responses are recorded. The only place your name will appear is on the optional contact postcard, which will be mailed separately from your questionnaires. The contact postcard has no code number on it so there is no way of identifying you (matching your responses on the questionnaires to your name). The optional contact postcard will be kept separate from the questionnaires in a locked file in Dr. Wright's laboratory. All forms containing data will be retained for a minimum of three years in a locked file in the principal investigator's office.

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Please keep this form for your records instead of returning it with the questionnaires. Returning the questionnaires indicates you have read the purpose and requirements of the study and indicates your consent for use of the answers you supply. If you choose not to participate in the study, please simply discard these materials.
As was stated in the advertisement, you are being invited to participate in a research project entitled "Sexual victimization: An examination of variables predicting psychological adjustment." This research is intended to study how women (18 years of age and older) cope with a variety of stressful or traumatic experiences (e.g., sexual assault, loss of a loved one, relationship difficulties). So you are aware, this research involves exposure to sexually explicit questions, with a considerable focus on past unwanted sexual experiences. This project will serve as Janine M. Schroeder's dissertation project.

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