The psychological impact of childhood sexual abuse (CSA) has been well documented: a meta-analytic review of the literature revealed a significant relationship between abuse and a wide variety of symptoms including anxiety, anger, depression, self-mutilation, sexual problems, substance misuse, suicidality, impairment of self-concept, interpersonal problems, obsessions and compulsions, dissociation, post-traumatic stress responses, and somatization (Neumann, Houskamp, Pollock, & Briere, 1996). There has been particular interest in the factors that mediate the relationship between CSA history and psychological distress. Polusney and Follette (1995), drawing on a more general model of psychopathology developed by Hayes and colleagues (1996), suggest that many of the common problematic behaviors and symptoms related to CSA are driven by experiential avoidance. Experiential avoidance, as it relates to CSA, is defined by Polusney and Follette (1995) as the “unwillingness to experience unpleasant internal events such as thoughts, memories, and affective states associated with an abuse history, and subsequent attempts to reduce, numb, or alleviate these negatively self-evaluated internal experiences” (p. 158).

While on the surface avoidant coping strategies such as emotional suppression and denial seem reasonable and even adaptive, there is increasing evidence that they may paradoxically perpetuate the very distress they aim to suppress (e.g., Gold & Wegner, 1995; Hayes et al., 1996; Wenzlaff & Wegner, 2000). There has been growing support suggesting that experientially avoidant coping strategies mediate the relationship between CSA and psychological distress (e.g., Batten, Follette, & Aban, 2001; Leitenberg, Greenwald, & Cado, 1992; Marx & Sloan, 2002).

One of the most serious consequences of exposure to CSA may be that women with such a history are at a significantly increased risk for being victimized again in the future (revictimization) (e.g., Gidycz, Coble, Latham, & Layman, 1993; Messman & Long, 1996; Wyatt, Guthrie, & Notgrass, 1992), and revictimization has been associated with even higher rates of psychological distress. For instance, one study using a large sample of college women compared students with different types of sexual victimization history (child only, adult only, child and adult, no abuse) on a well-validated multi-dimensional measure of trauma-related psychological functioning (Briere & Runtz, 1989). Women with childhood and adult victimization histories scored significantly higher on all scales of the Trauma Symptom Checklist-40, compared to women with a single abuse history or no history at all. Arata (1999), using a similar design, described revictimized women to have significantly more lifetime diagnoses than nonvictims and were significantly more likely to have a lifetime diagnosis of
PTSD than women with either a child-only or adult-only sexual assault history using the Structured Clinical Interview for the DSM III-R.

Many of the behavioral strategies used by CSA survivors to cope with their internal experiences may be life interfering in and of themselves and more importantly may actually increase the risk of future revictimization. Dissociation, substance abuse, compulsive sexual behavior, disordered eating, and dissociation common behaviors associated with childhood sexual assault, are conceptualized as attempts that are made by abuse victims at reducing, numbing, and alleviating their negatively self-evaluated internal experiences (Hayes, 1987; Polusney & Follette, 1995). While these individual coping strategies can significantly increase a woman’s risk of sexual victimization, the literature has found very little evidence to support this. In a review of recent studies, Messman-Moore and Long (2003) compellingly argue that no one variable is likely to be responsible for the link between CSA and revictimization. Instead, a unified theory is needed that conceptualizes increased risk for revictimization as the result of a compilation of related predictors.

This study proposes that experiential avoidance may account for the majority of symptoms and behaviors that place CSA survivors at an increased risk for revictimization. We will present data comparing women with a history of a single assault to those who have been revictimized to demonstrate the relevance of experiential avoidance to this population.

Method

Participants

Thirty-seven women were administered a series of questionnaires as part of a larger study on sexual revictimization. Childhood sexual victimization was defined as sexual contact that ranges from fondling to intercourse occurring before the age of 17 years that either: (a) occurred without consent or was unwanted, (b) was perpetrated by a family member, or (c) was perpetrated by a person more than 5 years older than the victim. Sexual revictimization was defined as women who have a history of childhood sexual abuse who are later victimized again in adulthood. Using these selection criteria, the final study sample consisted of 24 women, with a mean age of 19.6 years (ranging from 18 to 25). Nineteen were Caucasian, and 24 heterosexual. Seventeen women met the criteria for sexual victimization and seven for sexual revictimization.

Measures

Sexual Experiences Scale (SES; Koss & Oros, 1982) is a self-report instrument consisting of 10 yes/no items designed to assess various degrees of sexual victimization. Two versions of this measure were administered with slightly altered directions for completion. The first version assessed history of childhood sexual assault defined as events that occurred before the age of 17. The second version asked respondents to indicate any sexual victimization that occurred after the age of 18.

The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) is a 36-item measure of difficulties with various aspects of emotion regulation, defined as the ability to
notice, understand, and modulate one’s emotions so as to engage in chosen activities and refrain from unwanted actions. The scale provides a total score as well as 6 subscale scores measuring difficulties in aspects of emotion regulation, including: nonacceptance of emotions, ability to engage in goal-directed behavior when distressed, impulse control, awareness of emotions, access to strategies for regulation, and clarity of emotions. Participants indicate how often each item applies to themselves on a 5-point Likert-type scale, with 1 as almost never (0-10%) and 5 as almost always (91-100%). Higher scores indicate greater difficulties in emotion regulation.

Results

Characteristics of Sample

Prior to testing the experimental hypotheses, the data were examined to rule out several possible confounding variables. Age ($t[23] = 0.18, p < .86$), ethnicity ($\chi^2(3, N = 24) = 2.71, p < .44$), sexual orientation ($\chi^2(1, N = 24) = 2.21, p < .14$), and the semester in which the data were collected ($\chi^2(1, N = 24) = 1.02, p < .31$) were compared across the two groups (revictimized and victimized), yielding no significant differences.

Analyses

To test the hypothesis that women suffering from multiple episodes of sexual victimization (revictimized) differ from women who have suffered a single incident (victimized), independent sample one-tailed $t$-tests were conducted for the subscales of the DERS. Significant results were observed on the Strategies and Nonacceptance subscales. On the Strategies subscale, revictimized ($M = 20.13, SD = 8.34$) participants tended to score higher than victimized ($M = 14.24, SD = 5.15$) participants, $t(23) = 2.18, p < .02$, with a large effect size, $d = .91$. Similar results were found for the Nonacceptance subscale, on which revictimized ($M = 14.25, SD = 5.04$) participants also obtained higher scores than victimized ($M = 11.00, SD = 3.12$) participants, with $t(23) = 1.99, p < .03$. A similarly large effect size ($d = .83$) was noted. See Figure 1 for a graphical representation of these results.

Figure 1: Victimized vs. Revictimized for the Strategies and Nonacceptance Subscales of the ERDS
Discussion

The data from this study provide modest, preliminary support for the theory that revictimized women use more emotionally avoidant coping skills than women with a history of a single assault. These results are consistent with the theoretical model proposed by Hayes (1987) and Polusney and Follette (1995) that conceptualize experiential avoidance as a risk factor for revictimization. The significant difference of the Nonacceptance and Strategies subscales of the DERS suggests that revictimized women have significantly more difficulty modulating their emotions compared to women with a history of a single assault. Specifically, they may be appraising their negative emotions more negatively and may feel they lack coping strategies for effective emotion regulation.

While the results from this study indicate a significant relationship between revictimization and avoidant coping strategies, a retrospective design such as this makes it impossible to determine causality. It is still unclear whether avoidant strategies adopted by CSA survivors contributed to future revictimization, or whether multiple sexual assaults contributed to the development of this particular coping strategy. However, these results encourage the development of prospective research in this area.

If the modest results from the current study are replicated, it may be that risk reduction programs aimed at reducing the rates of revictimization among women with a history of CSA would benefit from the inclusion of approaches that promote acceptance of internal experiences. We are currently developing a sexual assault prevention program that integrates components from Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 1999) aimed at helping women to 1) become more aware of their internal responses to events, 2) become more present in their lives by observing the here and now, 3) become aware of the judgments they make about their own thoughts and experiences, 4) develop a sense of compassion toward their internal experience, 5) break the automatic relationship between thoughts and behavior and 6) develop a sense of valued action.

References


Author Contact Information

Justin M. Hill
Department of Psychology
Suffolk University
41 Temple St.
Boston, MA 02114

justin.hill@suffolk.edu