FACTORS AFFECTING REVICTIMIZATION IN SURVIVORS OF CHILDHOOD SEXUAL ABUSE

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Structural equation modeling was used to examine how childhood sexual abuse (and other associated variables, such as family functioning and experiencing multiple forms of abuse) relates to revictimization and psychological distress. Participants were women who participated in Project HOW: Health Outcomes of Women interviews, a longitudinal study that spanned six waves of interviews. Only women with a history of childhood sexual abuse were included in the present study (n=178). Experiencing nonsexual child maltreatment in addition to childhood sexual abuse appears directly related to adult sexual and physical revictimization and indirectly related to psychological distress. Childhood sexual abuse alone was not predictive of revictimization or psychological abuse. This suggests that other mediating factors may explain the relation between CSA and revictimization found in other research. Clinical implications based on the results of the present study emphasize the importance of identifying children who have experienced multiple forms of abuse as particularly at risk for future victimization. In addition, providing interventions with a focus on education and empowerment might decrease risk for future violence and subsequent emotional maladjustment. Potential future research could examine the treatment outcomes and efficacy of these interventions as well as identify those mediating factors that increase the risk for adult revictimization for those individuals who experience only childhood sexual abuse.
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INTRODUCTION

Child Sexual Abuse

Sexual abuse is a prevalent societal problem. Researchers estimate that as many as one in three American females and one in six males are sexually abused in childhood (Faller, 1990). Sexual abuse is defined by a variety of behaviors. According to some definitions, sexual abuse does not have to involve physical contact; instead, it may involve non-contact, such as when sexual comments are made to a child. Non-contact sexual abuse can also include an adult exposing genitals to a child or engaging in voyeurism. Non-contact sexual abuse also occurs when a part of a child’s body is sexualized or becomes a fetish for an adult in a way that is apparent to the child. Sexual abuse of a child that consists of contact may include fondling, digital or object penetration, oral sex, and intercourse (Faller, 1990).

The age discrepancy between the offender and victim also defines whether child sexual abuse has occurred. Usually, for contact to be considered child sexual abuse there must be a significant difference between offender and victim’s developmental levels. This difference is typically a five-year or more difference in age; however, child to child sexual abuse can occur when the offender has greater power over the victim, when the offender has greater sexual knowledge than the victim and uses this knowledge to manipulate the victim, and when the act is not consensually for mutual exploration (Faller, 1990).

In addition to a gap in age and/or power between offender and victims, researchers have also attempted to define child sexual abuse in terms of the age of the victim. There is significant disagreement in regards to age of child and whether an unwanted sexual experience constitutes child sexual abuse. Some researchers use a cut off age of 18, according to most states’ protective services guidelines. Other researchers have designated an age of 16 (Faller, 1990). Still others
stipulate that age 16 may be the maximum cutoff if the offender is at least 10 years older (Finkelhor, 1979a). Unfortunately, there is no consensus among researchers as to the maximum age of a victim of child sexual abuse (Faller, 1990).

Another area that defines child sexual abuse (CSA) is the inability of a child to give consent to a sexual act with an adult, even if the child appeared to cooperate with the abuser. According to Finkelhor (1979b), children do not understand sex and its implications, nor can they say ‘no’ in the same way adults can. Even if children are not overtly threatened, threat still exists in an implicit context. They may depend on the adult in some way, or may fear losing the adult should they disclose the abuse. The size (physical power) differential is a threat in itself. Children are not cognitively or emotionally capable of giving informed consent to a sexual act.

The Impact of Child Sexual Abuse

General Effects of Child Sexual Abuse during Childhood

Finkelhor (1989) described the impact that child sexual abuse has on its victims. Children who experience sexual abuse often experience depression and anxiety, difficulties in school, and may be truant or runaways. Some children may act out sexually or display knowledge regarding sexuality that is inappropriate for their age. Children may also exhibit anger and aggression because of sexual abuse. Children experience these effects to varying degrees. Adams-Tucker (1982) described the factors that are believed to affect the impact of childhood sexual abuse on children, such as age of onset, chronicity, severity, and relationship to the offender. Other researchers identified level of threat (Ruch & Chandler, 1982) and nonabusing caregiver response to disclosure of abuse (Summit & Kryso, 1978) as moderators to the impact of child sexual abuse. Although evidence is mixed, some researchers believe that the younger the child when abuse occurs, the more lasting negative effects that child will sustain. Furthermore, the
longer the abuse occurs, the greater the impact. When intercourse occurs and is accompanied by force or a high level of threat, children often find adjustment more difficult as well (Adams-Tucker, 1982; Ruch & Chandler, 1982). Finally, a child’s relationship to the offender has also been found to be related to later adjustment (Tufts, 1984). When the abuser is someone the child trusts, the child must come to terms with the betrayal experienced at the hands of someone who was supposed to care for him or her. Some studies have found that the reaction a child’s non-offending caregiver provides may serve as a stress buffer for many of these effects. If a child is not believed, his or her sense of betrayal may be exacerbated.

**Traumagenic Dynamics Model**

Finkelhor and Browne (1985) developed a model of four significant effects of CSA on child survivors: sexualization, stigmatization, powerlessness, and betrayal. The authors assert that the presence of these trauma-causing factors affects the way a child perceives his or her world, as well as his or her self-concept, and ability to regulate emotions. As a result, many negative effects of child sexual abuse may stem from this distorted worldview.

To understand the traumagenic model of sexual abuse, each factor must be examined. The first factor is traumatic sexualization in which the offender uses the child as a sexual object. The child is reinforced for engaging in sexual behaviors that are unsuitable for the child’s current developmental stage. The child comes to identify sexual activity as a means to meet his or her needs and obtain attention and affection from others. Furthermore, the child may develop an aversion or fear of sexual activity that carries into adulthood (Finkelhor & Browne, 1985).

Betrayal occurs when someone on whom a child has depended to appropriately meet his/her needs hurts the child. Betrayal can extend beyond the relationship with the offender to the non-offending parent. Children who are not believed when they disclose abuse, or who are
blamed or treated negatively in some way feel betrayed by the reaction of those to whom they disclosed the abuse. Children may experience betrayal despite the degree of closeness to the offender when they feel tricked or manipulated into participating and as a result, feel deceived and foolish (Finkelhor & Browne, 1985).

Powerlessness is characterized by a sense of helplessness experienced by children who feel they are unable to stop or escape from the abuse they are experiencing. Their bodies are not their own, or choices about their bodies are made by others. Instead, child victims of sexual abuse are forced to bend to the will and desires of the offender, despite their protests or reluctance. Threat does not have to be explicitly stated by the offender to create feelings of powerlessness in child victims. Children often realize the implication disclosing abuse will have on the family, especially non-offending parents and siblings. The family may rely on the offender to provide economic support and they may lose this when the child discloses the abuse. Feeling trapped by circumstance such as these increase helplessness in the child to exert any control over his or her abusive situation (Finkelhor & Browne, 1985).

Stigmatization is the final traumagenic factor. Children who experience sexual abuse often feel as though they are damaged and believe that they are alone in their experiences. The offender as well as those to whom they eventually disclose the abuse often blame the abused children. These feelings of shame and guilt are then internalized and become part of how they child defines himself or herself (Finkelhor & Browne, 1985).

Many of the effects researchers have associated with childhood sexual abuse can be understood from a traumagenic perspective. Each of the traumagenic factors can be related to specific effects researchers have found to be associated with child sexual abuse. One effect of child sexual abuse previously discussed is that children who are sexually abused have more
sexual knowledge than is developmentally appropriate. They may act out sexually and experience sexual problems as adults and may view sex as a means to gain affection from others (Wyatt, 1990). These symptoms are related to being sexualized by the offender. Children who feel betrayed may experience depression and anxiety. They have difficulty trusting others and may become overly dependent and clingy with non-offending caretakers. Children who are stigmatized may experience low self-esteem and feel ostracized by others. Stigmatized children often blame themselves for the abuse and feel shame and guilt as a result. Finally, children who experience powerlessness as a result of sexual abuse are often anxious and fearful. They are also overly dependent on others and often experience nightmares, and physical complaints as a result of high levels of anxiety. They may be hypervigilant of their surroundings and develop phobias. Furthermore, children who are powerless to stop their abuse may develop feelings of depression and lack self-efficacy. In order to reduce feelings of inefficacy, children may become bullies or victimizers of others in order to regain a sense of control and to feel a sense of dominance over another person (Finkelhor & Browne, 1985; James, 1996).

The Impact of Child Sexual Abuse during Adulthood

Finkelhor and Browne (1985) conceptualized many of the problems adult survivors of CSA experience using the traumagenic dynamics model. The sexualized child often grows into an adult who has negative connotations associated with sexual experiences. The adult may engage in many unsafe and unsatisfying sexual relationships in an attempt to meet his or her emotional needs (Arata, 2000; Wyatt, Guthrie, and Notgrass, 1992). The adult survivor of child sexual abuse may in turn avoid sexual relationships or experience sexual problems (Finkelhor and Brown, 1985). In addition, child sexual abuse increases the risk for sexual revictimization as adults (Arata, 2000; Koss and Dinero, 1989) The stigmatized child becomes an adult who may
attempt to self-medicate feelings of guilt and shame through the use of alcohol and drugs (Gibson and Leitenberg, 2001). Some engage in prostitution and other criminal behaviors. For some, the view that they are “damaged goods” will continue into adulthood and result in poor adjustment (Coffey, Leitenberg, Henning, Turner, and Bennett, 1996a; Kallstrom-Fuqua, Weston, and Marshall, 2004). In adulthood, the betrayed child may have a difficult time determining who is trustworthy and who is not. This may also contribute to the adult survivor’s increased risk of revictimization, as well as greater psychological distress (Filipas and Ullman, 2006). Lastly, the powerless child may become an adult who continues to struggle with problems feeling unable to affect change and control over his or her life. The feelings of helplessness may turn to despair and result in suicidal ideation and attempts (Finkelhor and Brown, 1985)

Revictimization

In this context, revictimization is defined as a survivor of CSA experiencing adult sexual and/or physical abuse. Past research has found a relation between CSA and sexual revictimization (Classen, Palesh, & Aggarwal, 2005; Messman & Long, 1996). Previous research suggests that CSA is the best predictor of sexual revictimization. Experiencing CSA doubles, and in some cases, triples the risk for adult revictimization (Fleming, Mullen, Sibthrope, & Bammer, 1999; Wyatt, Guthrie, & Notgrass, 1992). Although researchers generally agree that childhood sexual abuse is a risk factor for adult victimization, studies have yielded contradictory findings in regards to the impact of other variables (e.g., family functioning and parental support) associated with child sexual abuse and there influence on adult revictimization. Not everyone who experiences CSA is revictimized; researchers have been attempting to discover which variables combined with CSA increase a survivor’s risk. Additionally, there is very little information as to
what factors might buffer the effects of CSA and decrease the likelihood of revictimization. The following section will discuss factors associated with adult revictimization.

Factors Associated with Adult Revictimization.

The Cumulative Effect of Childhood Traumas

Researchers have recently attempted to establish whether the level of distress resulting from childhood trauma is cumulative in nature. Messman-Moore and Brown (2004) examined three forms of child abuse (emotional, physical and sexual) in a sample of college women and predicted that all three would be related to adult sexual assault. In addition, they hypothesized that those children who had experienced more than one type of abuse would be at greatest risk for future victimization. The authors found that childhood physical abuse rarely occurred independently from other types of abuse. Therefore, they chose to examine the cumulative effect of childhood abuse on adult sexual assault. The researchers discovered that women who reported multiple types of childhood abuse were at the greatest risk for adult sexual revictimization. The next greatest risk for victimization was for women who experienced two types of abuse, followed by women who reported one type of child abuse. These women were at a greater risk than those who had experienced no child abuse. The strongest predictor of adult sexual revictimization was CSA. Child physical abuse alone did not predict adult sexual assault.

In a study of undergraduate females, Arata and Lindman (2002) found that child physical abuse was a better predictor of adult sexual revictimization than child sexual abuse; however, this finding differed depending on the marital status of the participant. The researchers discovered that child physical abuse and dating behavior was the better predictor of sexual revictimization for single women. Because child physical abuse and dating behavior were not correlated, the authors determined that child physical abuse independently affected
revictimization rates. Child sexual abuse, as well as age, were related to adult sexual revictimization for women. When a married woman was younger, she was found to be at greater risk for future revictimization. The authors explained this finding by the fact that sexually abused women may be more likely to get married in order to escape their home lives. As a result, they may be more likely to be at risk for abusive marital relationships, or they may divorce early and find themselves at risk for sexual victimization.

*Family Functioning*

Many studies have found family dysfunction to be associated with CSA. Studies of college women with a history of CSA (Hulsey, Sexton, and Nash, 1992; Jackson, Calhoun, Amick, Maddever, and Habif, 1990; Kern and Hastings, 1995) found that these women reported growing up in families with less cohesion, less emotional expressiveness, discouragement of independence, less time spent in family activities, and a greater degree of conflict and control in the family. Long and Jackson (1994) found women with a history of CSA described their family as more disorganized than women with no history of abuse. Koverola, Proulx, Battle, and Hanna (1996) found that college age women with a history of CSA reported less family support, commitment and help and experienced their families as more controlling, angry, and aggressive. They also reported more conflict among family members. Fergusson, Horwood, and Lynskey (1997) found that young girls with a history of CSA were more likely to have young uneducated mothers, and experienced unstable family relationships in which there was significant discord, more divorce, and step-parent involvement before age 15. These women also reported more physical punishment, less attachment to caregivers, low maternal care, and high maternal overprotection. Women with a history of CSA were also more likely to report growing up in homes with parents who abused drugs and alcohol.
Studies have also examined whether perceptions of family functioning differs for those who experienced intrafamilial versus extrafamilial CSA. Bal, De Bourdeaudhuij, Crombez, and Van Oost (2004) examined the family functioning of sexually abused adolescents and found no differences between perceptions of family functioning for intrafamilial versus extrafamilial abuse. They found that the level of family cohesion was a predictor of the internalization of trauma related symptoms. Sexually abused adolescents who reported low family cohesiveness were more internalizing of their abuse as evidenced by the greater presence of depression, PTSD, anxiety and dissociation. Reinemann, Stark, and Swearer (2003) compared groups of inpatient adolescents and found that adolescents who experienced child sexual assault were more likely to view their parents as more authoritarian and enmeshed, specifically indicating that they perceived family boundaries to be blurred. These findings remained significant for adolescents for both extra- and intrafamilial abuse.

Bennett, Hughes, and Luke (2000) examined whether specific aspects of CSA, such as characteristics of abuse and identity of the perpetrator, influenced perceptions of family functioning. Women who experienced severe CSA described their families as significantly less healthy than women who experienced mild CSA. There was also a difference in perceptions of family functioning between women who experienced severe extrafamilial abuse versus women who experienced severe intrafamilial abuse, with women experiencing severe extrafamilial abuse describing their family as more healthy. Although the severity of abuse was related to perceptions of family functioning for those who experienced severe and mild CSA, the authors theorized that for women who experienced abuse in the middle of the severity continuum, the duration of abuse and relationship to the abuser might be more related to perceptions of family functioning. Women who reported mild abuse reported their family as being healthier than
women who experienced severe abuse, or abuse that included some form of threat and/or intercourse.

Merrill, Thomsen, Sinclair, Gold, and Milner (2001) studied a group of female naval recruits. Women with a history of CSA described their families as less supportive than those with no CSA history. However, when the impact of family functioning on adjustment was statistically controlled, the effects of CSA continued to predict poor adjustment. The authors concluded that CSA was a better predictor of long term adjustment than family factors. Although their findings did not support family functioning as mediator of the relation between CSA and adjustment, they did acknowledged some limitations in their methods of assessing family functioning that could obscure the relation. Level of family cohesiveness and conflict were not assessed as they had been in prior studies.

Studies that have examined sexual assault in adulthood found that women described their family similarly to those who experienced CSA. Women who were sexually assaulted in adulthood also perceived their families as dysfunctional. Stermac, Reist, Addison, and Miller (2002) found that women who had experienced forceful sexual assault in adulthood described their families, in comparison to women who were not sexually assaulted, as less cohesive and less expressive, and they reported that they did not feel as close to either parent. In fact, they found that a negative parental relationship, the absence of a father, and neglect by the mother were predictive of adult sexual assault. Siegel and Williams (2003) found women who were sexually victimized in adulthood also had chaotic upbringings, as compared with women with no history adult victimization, with an average of 4.5 different living situations while growing up, in addition to multiple caregivers throughout childhood and strict punishment by mothers.
Research on the association between CSA and negative family functioning led researchers to speculate that women with a history of CSA and dysfunctional families were at greater risk for sexual revictimization. Fergusson et al. (1997) found that young women with a history of CSA were more likely to come from dysfunctional families that were prone to child sexual abuse which resulted in an increase in sexual risk taking behavior at a younger age and later sexual revictimization. Messman-Moore and Brown (2004) examined perceptions of family functioning by women who experienced multiple forms of abuse during childhood, including sexual (CSA), physical (CPA), and emotional (CEA) abuse as well as adult rape. The researchers examined the women’s perceptions of family functioning in terms of family cohesion, expressiveness and conflict. They hypothesized that women who were abused would view their families as lacking in cohesion and emotional expressiveness and would view their families as having more conflict than the nonabused comparison group. They found that this was true only for women who experienced child physical abuse, child emotional abuse and adult rape. Women who experienced CSA did not differ significantly from the nonabused group. The authors suggested that CSA and family dysfunction were not related because CSA does not always occur within the home, as CPA and CEA typically do. Women reporting two or three forms of abuse reported more family dysfunction than women who experienced one type of abuse or no abuse. It would appear those women who experienced cumulative trauma as children experienced their families as less cohesive, less emotionally expressive, and more conflictual.

Messman-Moore and Brown (2004) also examined the forms of abuse individually in addition to perceptions of family functioning variables in order to predict adult rape. They found CSA to be a predictor of sexual revictimization independent of family functioning. They also noted that a lack of family cohesion predicted revictimization. However, upon further analysis,
cohesion predicted revictimization only when emotional abuse was not present during childhood. In other words, when child emotional abuse was absent, the risk of adult rape increased as perceptions of family cohesion decreased. The authors concluded that family cohesion would therefore be a protective factor, but only when CEA is absent. When CEA was present, a family environment that discouraged emotional expression also increased the risk for adult sexual revictimization. A lack of emotional expression was not a risk factor for adult rape when CEA was absent. Therefore, CEA may affect one’s ability to stand up for herself, lower self-esteem and have an impact on later relationships, thus resulting in an increased risk of later sexual assault. CPA was not predictive of sexual revictimization unless it occurred in combination with other forms of abuse; the authors suggested that CPA may be more predictive of adult physical revictimization (which was not assessed). However, the authors encouraged caution given the few women in the study that had experienced CPA. They also cited the small number of family variables studied as a limitation to the study. They speculated that other variables, such as a chaotic home life, parent substance use, or domestic violence may have an affect on perceptions of family functioning and increase risk for future victimization. Other researchers (Siegel and Williams, 2003; Stermac et al., 2002) found that women who were exposed to domestic violence as children were at greater risk for adult sexual assault.

Many studies have examined the negative relation between CSA and family functioning. A few researchers have also examined family variables that could potentially protect a CSA survivor from negative outcomes in adjustment. One factor thought to moderate the relation between CSA and later adjustment is parental support, although findings have been contradictory. Early studies (Testa, Miller, Downs and Paneck, 1992; Wyatt and Mickey, 1987) found that parental support had a positive impact on long-term adjustment, and teachers reported
higher self-esteem and fewer behavior problems in children who had parental support shortly after disclosure (Tremblay et al., 1999). Studies that are more recent have not found similar associations between CSA and parental support. Merrill et al., (2001) did not find parental support to be important in adjustment. It should be noted that these latter authors compared parental support and the adjustment of victims versus nonvictims--whether parental support was more helpful depending on whether one was abused. Authors found that parental support was equally beneficial for victims and nonvictims, and for all individuals with a history of CSA regardless of the characteristics of the abuse. Thus, they showed parental support to be a positive predictor of psychological outcomes, although not a specific buffer for CSA.

Jankowski, Leitenberg, Hanning, and Coffey (2002) examined perceived parental warmth as a possible protective factor in preventing sexual revictimization in undergraduate women. The authors did not find overall parental warmth to be a shield against future revictimization, but did find paternal caring to decrease chances for future victimization. The authors suggested that a caring father serves as an example of a positive male, and women are therefore less likely to become involved with exploitive and physically and sexually violent men. The same results were not found for maternal caring. The authors suggested that the overall lack of effect of parental caring might be the result of other variables that have a larger influence on revictimization that may be too great to be buffered by caring parents. For example, the use of alcohol and drugs may put women at risk for future victimization; when this occurs in a woman’s life, the influence of peers as opposed to parents may be greater. Furthermore, the impact of negative coping, such as emotional avoidance, may not be affected by parents’ efforts to create a warm and caring environment. Another possible reason why these studies did not find an effect might be that they evaluated perceptions of support as opposed to actual perceived messages from significant others.
while growing up. Perhaps children who receive messages that boost their self-efficacy would utilize more adaptive means of coping and therefore find themselves at decreased risk for future physical and sexual revictimization.

Given that findings regarding family functioning’s effects on revictimization are mixed, Arata (2002) suggested it may be better to examine family functioning in terms of its indirect effect on revictimization. She suggested that family functioning may influence other variables that better predict one’s risk for adult victimization. For example, Messman-Moore and Brown (2004) theorized that as a result of growing up in a dysfunctional family, a woman may have low self-esteem and a poor understanding of healthy intimacy in relationships, leading to an increased risk for revictimization. In this case, family functioning would not directly increase risk for revictimization, but would impact other variables that have a more direct influence on revictimization.

**Alcohol/Substance Use**

Studies have found a relation between CSA and substance use. Results from the National Comorbidity Survey found a significantly higher lifetime prevalence rate for alcohol dependence in women who experienced CSA than nonabused women (Molnar, Buka, and Kessler, 2001). Raghavan and Kingston (2006) found that women who were sexually abused as children started using substances, including alcohol, at an earlier age than women who did not report abuse as children. Jarvis, Copeland, and Walton (1998) also found that women who experienced CSA reported being intoxicated at an earlier age than women with no history of CSA. Their study also suggested CSA survivors are at an increased risk for substance abuse during adolescence. Other studies have found that past substance use is related to both severity of CSA, as well as duration of the abuse (Liu, Longshore, Williams, Rivkin, Loeb, Warda, Carmona, and Wyatt, 2006).
Research has suggested that alcohol and substance use seem to be related to revictimization as well. Messman-Moore and Long (2000) found that revictimization in women with a history of CSA was associated with alcohol and substance use. Filipas and Ullman (2006) found that women who were revictimized were more likely to use alcohol and other substances to cope than were women who experienced CSA without revictimization. Other studies have tried to determine whether assault causes use or use causes the assault. In one study, drug use was found to be related to a higher risk of revictimization; however, alcohol use was not. Both alcohol and drug use were a means of coping after assaults, and women who experienced a new sexual assault seemed to increase their use of drugs and alcohol. These results suggested that the relation between alcohol and substance use and sexual assault is likely bidirectional in nature (Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997).

Briere (2004) suggested that some abuse survivors have difficulty regulating the turbulent emotions resulting from past abuse. Therefore, as a means of “tension reduction behavior,” they turn to dysfunctional methods of soothing, such as substance abuse and other ineffective coping strategies. Substance abuse becomes a means of self-medication in order to numb oneself to the negative feelings associated with the abuse. Siegel and Williams (2003) studied 206 low income African American women who had been sexually abused before age 13. They found that women who abused alcohol were more than three times more likely to be victimized as adults than women who did not drink. The authors found that women who were sexually assaulted drank more which increased the number of sexual partners the women had and thereby increased their risk for sexual assault. Koss and Dinero (1989) suggested that increased alcohol use makes it more difficult for women to accurately perceive signals that they are in a dangerous situation and
puts them at an increased risk for sexual assault. The authors also indicated that perpetrators may view a woman’s inebriated state as a sign that a woman is open to having sex.

**Psychological Distress**

As discussed previously, individuals who experience CSA often experience significant distress during childhood that continues into adulthood. Research has also examined specific psychopathology experienced by survivors of CSA as well as those who are later revictimized. Molnar et al. (2001) found that women who were sexually abused as children had higher lifetime prevalence rates of mood disorders, anxiety disorders and substance dependence than did the average population. Messman, Long, and Siegfried (2000) studied reported psychopathology among college students who experienced CSA only and women who experienced CSA and later physical or sexual revictimization. They did not find major differences in pathology for women with CSA only and women who were revictimized. Both groups reported somatic complains, depression, anxiety, interpersonal sensitivity, hostility and posttraumatic stress disorder (PTSD) symptoms. The only notable differences between the CSA only group and the revictimization groups were that women who were revictimized reported more somatic complaints than the CSA only group, and women with multiple revictimizations reported greater symptoms of depression than the CSA only group. The authors suggested that perhaps cumulative trauma throughout one’s life, rather than child to adult revictimization may be a better predictor of psychological adjustment.

Many studies examining psychological adjustment in relation to CSA focus on PTSD symptoms. Filipas and Ullman (2006) found that among college students with a history of CSA, maladaptive coping (drug use, social withdrawal, and sexual acting out), severity of CSA, and the presence of self-blame were related to the severity of PTSD symptoms; however, self-blame,
severity of CSA and PTSD symptoms were not predictive of revictimization. Instead, women who engaged in maladaptive coping strategies were twice as likely to be revictimized as those who did not use such strategies.

Arata (2000) attempted to develop a model to predict sexual revictimization using a college sample. She hypothesized that individuals who were sexually abused for a longer time period, had more physical contact with the abuser, were more familiar with the abuse, and experienced greater force were at greatest risk for revictimization. She also suggested that women who were revictimized would engage in more self-blame for the CSA, have more PTSD symptoms, and would engage in more consensual sexual activity than CSA survivors who were not revictimized. She found that greater physical contact was the only CSA characteristic that was predictive of mediating variables, and was therefore the only variable included in the final model. She found that the greater the physical contact, the more likely the survivor was to blame herself, have more PTSD symptoms, and more sexual partners. The final model suggested an indirect relation between CSA and adult revictimization. According to Arata (2000), revictimization is the result of other mediating variables such as self-blame, PTSD symptoms, and frequent consensual sexual activity. Other studies have also found self-blame, as well as blaming fate, to be associated with more psychological dysfunction than blaming the perpetrator (Feinauer & Stuart, 1996).

Although the variables in Arata’s (2000) study (severity of abuse, self-blame, PTSD symptoms and frequent sexual activity) allowed for the significant prediction of revictimization, the model did not account for a large proportion of the variance in revictimization. Thus, the author encouraged future researchers to examine additional variables, such as family functioning and alcohol use. The author was also unsure as to whether the mediating factors were predictive
of revictimization or effects of further victimization. Whereas Arata’s (2000) study found that PTSD mediated the relation between CSA and revictimization, another study (Sandberg, Mantorin, and Lynn, 1999), using prospective reports of undergraduate survivors of CSA, found that PTSD symptoms moderated the relation between CSA and revictimization. They found a significant interaction between childhood/adolescent sexual victimization and posttraumatic symptoms indicating that the presence of posttraumatic symptoms is required for childhood/adolescent sexual victimization to robustly predict adult sexual revictimization.

Sandberg et al’s (1990) findings underscore the importance of assessing PTSD symptoms when examining revictimization. Women with PTSD symptoms may be at an increased risk for revictimization due to the distressing and intrusive thoughts that accompany PTSD that decrease one’s capacity to identify threatening situations as dangerous. The hypervigilance associated with PTSD further makes it difficult to distinguish truly threatening from nonthreatening stimuli, as the individual is constantly vigilant within his/her everyday environment. Therefore, it is difficult to distinguish real from imaginary threat (Chu, 1992). Wilson, Calhoun, and Bernat (1999) found that hypervigilence desensitizes CSA survivors to actual threat. Barlow (2002) identified that because of this desensitization, survivors tend to ignore cues of danger and inhibit fear responses, as this has proved adaptive in their everyday lives in which they perceive constant danger. Unfortunately, when differential actual danger cues exist, the survivor often fails to perceive the true and dangerous nature of the threat or to respond appropriately, thereby increasing the risk of revictimization.

Intimate Partner Violence as Revictimization

Although there are many studies examining sexual revictimization, it should be noted that revictimization could also include intimate partner violence (IPV) in adulthood. Studies have
estimated that as many as 48% of female victims of CSA grow up to be in physically abusive partner relationships (Walker, 1984). Other studies have also found an association between a history of CSA and adult physical maltreatment (Messman-Moore and Long, 2000; Lang, Stein, Kennedy & Foy, 2004). Noll, Horowitz, Bonanno, Trickett, and Putnam (2003) found that physical revictimization was associated with posttraumatic stress disorder symptoms, dissociation and sexual promiscuity. Furthermore, Griffing et al. (2005) also found that CSA survivors are more likely to return to their batterer, and separate from the batterer more frequently than those with no history of CSA. They suggested that women with a history of CSA are more likely to return to an abusive relationship because of an emotional attachment to the batterer and because they feel sorry for him after he expresses regret.

DiLillo, Giuffre, Tremblay, and Peterson (2001) found that the presence of CSA, irrespective of the severity of abuse, was a predictor of a variety of aggressive interpersonal behaviors. Furthermore, their study was unique because they examined the presence of mutual abuse in relationships, and found that CSA survivors were more likely to have engaged in intimate physical violence against their partners than women who had never experienced CSA. One limitation of their study, however, is that the number of women in the study who were categorized as CSA survivors was likely inflated as a result of the age range used in the definition of CSA, as well as the difference in ages between perpetrator and victim. CSA was considered to have occurred if the victim was 18 or younger and only a difference of three years between victim and perpetrator (as opposed to five years as is normally used in the literature).

Hypotheses and Research Questions

The current study sought to expand upon many of the issues currently of interest in the field of child sexual abuse and future adult revictimization. Generally, past studies have taken an
“either/or” approach to studying revictimization, either looking at cognitive variables or behavioral variables. This study sought to be one of the first to examine simultaneously the cognitive, emotional and behavioral factors associated with both physical and sexual revictimization in women with a history of CSA. The majority of studies also use predominantly white, high socioeconomic status, undergraduate women as participants; this study examined women who fell below the poverty line and were more culturally diverse.

The focus of this study was to use sophisticated statistical analyses to identify a model of factors associated with both physical and sexual revictimization in survivors of CSA. Based on the reviewed literature, factors associated with CSA that were purported to predict physical/sexual revictimization were operationalized and evaluated. These factors included: (1) characteristics of childhood sexual abuse as indicated by number of assaults, age at first assault, number of perpetrators, type of force used, and identity of perpetrator; (2) nonsexual childhood maltreatment, indicated by psychological aggression, minor aggression and severe aggression; (3) negative family functioning, as indicated by negative childhood messages, number of traumatic events in childhood, and parental drinking/drug use, (4) level of psychological distress, as indicated by current substance/alcohol use, and severity of symptoms related to somatization, anxiety, PTSD, dissociation, and an overall score of general psychological distress. It was proposed that that CSA characteristics, family functioning and nonsexual child maltreatment independently predict psychological distress, alcohol/substance use and adult revictimization. See Figure 1 for a depiction of this direct effects model.
Figure 1. Proposed direct effects model. An alternative to this model would be that psychological distress and would function as a mediator between childhood factors (CSA characteristics, family functioning, and nonsexual child maltreatment) and adult revictimization (See Figure 2).
Figure 2. Proposed mediational model.
METHOD

Participants

Participants were women who participated in Project HOW: Health Outcomes of Women interviews, a longitudinal study that spanned six waves of interviews. Women were financially reimbursed at each wave in which they participated. Women who were eligible for the study were in a committed heterosexual relationship, and their income was below the poverty line. A total of 835 women participated in the study at Wave 1 (Kallstrom-Fuqua, Weston, & Marshall, 2004). For the purpose of this study, only women who reported a history of childhood sexual abuse were included ($N = 183$). In regards to ethnicity of the sample, 31% were African American ($n = 56$), 30% were Hispanic ($n = 74$), and 40% were European American ($n = 73$). The participants’ ages ranged from 19-48 ($M = 33, SD = 7.940$). In regards to the participants’ relationship status, 8% were dating ($n = 15$), 12% were cohabitating ($n = 22$), 17% were in common-law marriages ($n = 32$), 43% were married ($n = 79$), 15% were separated ($n = 28$), 4% were divorced (4), and 2% were widowed ($n = 2$).

Measures

Indicators of child sexual abuse were single item indicators, as were the participants’ current alcohol/substance use and parental alcohol/substance use.

Demographic Information

Demographic information from Wave 1 included information regarding participants’ age, ethnicity, marital status, and education.

Child Sexual Abuse Characteristics

Interviewers at Wave 3 asked women detailed questions about their history of sexual abuse. Questions regarding women’s history of sexual abuse were introduced. Variables that
were associated with sexual abuse were assessed by asking the following questions: (1) Has anyone besides a date or partner used a weapon of any kind to make you have sexual intercourse or any other sexual act? (2) Has anyone besides a date or partner physically forced you to have sexual intercourse or any other sexual act? (3) Has anyone besides a date or partner ever used threats of physical force to make you have sexual intercourse or any other sexual act? (4) Has anyone besides a date or partner pressured, convinced, deceived or tricked you to have sexual intercourse or any other sexual act like touching or fondling? (5) (other than that) has anyone besides a date or partner touched you or fondled you in a sexual way when you did not want them to? The number of incidents of abuse, the number of offenders, as well as the duration of abuse was recorded. Age at time of occurrence, who committed the act, whether the offender was a male or female, when the victim told someone, who they told, how telling made her feel, how old she was the last time it happened were also coded. Touching and fondling were assessed through questions regarding whether the abuse occurred as an adult or child, was it ever done at work, did she ever try to report it, did she consider it sexual harassment, and if it happened during childhood, was the perpetrator another child or an adult? Participants were also asked whether they were believed when they disclosed, and if not, who did not believe her? Whether these incidents occurred in the context of a relationship with a partner or boyfriend and whether the incidents occurred within the context of a date were also coded.

For the purpose of this study, child sexual abuse is defined as women who experienced sexual abuse before age 18. In addition to age at offense, who committed the act was also examined to determine whether intrafamilial versus extrafamilial abuse occurred. Severity of abuse was considered, as well as age at time of abuse, and chronicity of abuse. Touching and
fondling was included as forms of sexual abuse; however, only those childhood incidents that were perpetrated by an adult were considered for the purpose of the child sexual abuse variable.

Revictimization

Incidents of physical or sexual assault occurring after age 18 will be considered revictimization. The Severity of Violence Against Women Scales (SVAWS) was used to measure participants’ experiences with sexual, physical and emotional intimate partner violence (IPV). Subscales included threats of violence, physical aggression and sexual aggression. Reported alphas ranged from .92-.96 (Marshall, 1992). The SVAWS has been used in prior studies to identify the frequency and severity of abusive behaviors (Levendosky, Huth-Bocks, and Semel, 2002; McFarlane, Wilson, Malecha, & Lemmey, 2000). Participants were asked to rank the frequency of abusive behaviors on a 9 point Likert scale ranging from 0 (never happens) to 9 (happens almost daily). Items comprising the subscales were averaged to obtain scores. Women were also interviewed regarding unwanted sexual experience with a stranger. These items are not considered part of the SVAWS.

Child Physical Abuse

The Conflict Tactic Scales is frequently used to measure verbal and physical family violence. Eleven items from the twenty-item Parent-Child Scale of the Conflict Tactics Scale were used to measure the frequency of threats of physical aggression and acts of violence against children (Straus, 1979). Subscales included psychological aggression, minor aggression and severe aggression. All items were rated on a Likert scale. Because this is a unique application of a subset of items on the Parent-Child Scale, the internal consistency of the scale was computed and found to be good ($\alpha = .91$). Scores are obtained by averaging items from each subscale.
Concurrent validity for the overall measure was determined through agreement of family members regarding incidents of violence, although victims tend to endorse more incidents of violence than perpetrator. The overall measure also appears to have good construct validity, as studies have found associations between antecedents and consequences of family maltreatment and the CTS (Schumm & Bagarozzi, 1989).

**Family Functioning**

Participants were asked whether either parent had a drinking problem or problem with substances while the participants were growing up.

Interview questions were also asked regarding nonabuse-related childhood trauma. The scale was developed from Norris’ (1990) 14-26 question Traumatic Stress Schedule and includes 14 questions regarding traumatic and distressing events that occurred in the participant’s family of origin. The purpose of the original scale was to identify traumatic events and associated posttraumatic stress disorder symptoms. It has been used in studies examining the relation between child abuse and obesity, PTSD and suicidal intent in low income women, and the impact of new traumatic events on individuals with a previous trauma history (Alvarez, Pavao, Baumrind, and Kimerling, 2007; Buchanan, Stephens, Nigel, 2001; Reviere, Battle, and Farber, 2003). Included in the adapted measure were questions regarding events related to the family of origin to further assess childhood family functioning. Participants were asked how many times each event happened to them and how old they were at the most recent time. Participants rated how much the event bothered them at the time, and how much the event bothers them now on a Likert scale. Scoring of the measure involves summing all items of the scale.
Participants were also interviewed about the frequency of positive and negative messages received during childhood, messages they received when someone treated them badly, as well as messages regarding their ability to get through difficult times. Items regarding the frequency of positive and negative messages from caregivers were ranked using a 7 point Likert scale ranging from 1 (never received such a message) to 7 (always received such a message). Items regarding the likelihood of receiving positive/negative messages when treated badly in childhood and the likelihood of receiving certain messages about abilities to endure difficult times were also ranked on a 7 point Likert scale ranging from 1 (not at all likely) to 7 (extremely likely). Scores are obtained by averaging scale items.

Alcohol Use

Participants were interviewed about their alcohol use. Frequency of use was assessed using a Likert scale ranging from 0 (never drinks) to 11 (drinks several times per day).

Psychological Distress

Psychological distress was reflected by the Global Severity Index (GSI) of the Symptom Check List-90 (Derogatis, Lipman, and Covi, 1973). The SCL-90’s internal consistency ranges from .77-.90 (Derogatis, Rickels, and Roch, 1976). It has been used in community samples to measure psychological distress (Preti, Incani, Camboni, Petretto, and Masala, 2006; Amir and Le-Wiesel, 2003; Merikangas, Stevens, and Angst, 1993). Briere and Runtz’s (1990) dissociation scale was also used to assess psychological distress. This 14-item scale was created in order to augment the Hopkins Symptom Checklist and has a reported alpha of .85-.90. The scale has been used in studies as a measure of dissociation symptomatology typical of PTSD (Temple, Weston, Rodriguez, and Marshall, 2007; Kallstrom-Fuqua et al., 2004; Cloitre, Koenen, Cohen, and Han, 2002). Portions of Saunders, Arata, and Kilpatrick’s (1990) 28 item Crimes-related PTSD
Disorders Scale (CR-PTSD) was used to measure PTSD symptoms. The scale has been used in identifying PTSD symptoms, (Richter, Waydhas, and Pajonk, 2006; Swan, Gambne, Fields, Sullivan, and Snow, 2005) and the scale has also been useful in discriminating sexually assaulted women from nonsexually assaulted women (Saunders et al., 1990). Reported internal consistency of the scale has ranged from alpha = .87 to .96 (Sullivan, Meese, Swan, Mazure, and Snow, 2005; Campbell, Sefl, and Ahrens, 2004). Participants were asked on all three scales how much symptoms bothered them within the last month using a 5 point Likert scale ranging from 0 (not at all) to 5 (extremely bothered). Scores are obtained by averaging scale items.

Procedure

Arrangements were made with the principal investigator of Project HOW to utilize the data for the present study. What follows is a description of the Project HOW data collection procedures.

Flyers were distributed throughout the desired geographical area in the community to recruit participants. Participants were also identified by attending public events in this area in order for recruiters to establish contact with women who met criterion for participation. Friends and family also referred some women. A total of 998 women were initially selected for interview; however, some did not qualify for participation, either because they did not meet age or relationship criteria. Women were also disqualified for participation because they did not meet the socioeconomic requirements of the study. (Marshall, 1999).

Care was taken to ensure the confidentiality of the women who participated in the study. The overall study received a National Institutes of Health Certificate of Confidentiality, ensuring the women that the information they individually provided would not be released without their written consent. Interviewers knew women only by minimally identifying information (first
name, mother’s maiden name and birth date); and staff who assisted with paperwork were blind to the purpose of the study and did not have access to the information obtained in the interviews (Kallstrom-Fuqua et al., 2004).

Research assistants carefully trained undergraduate interviewers in administering structured interviews used in the study. The interviews lasted approximately 2.5 hours. Interviewers were trained in how to appropriately deal with participants who became distressed as a result of the material included in the interviews. Furthermore, interviewer attitudes were monitored to ensure sensitivity to the issues discussed in the interviews. Some interviewers were let go as a result of their insensitivity. Interviewers were also asked to provide the women interviewed with telephone numbers of mental health agencies that could provide intervention services should it be needed after the interviews. Research assistants advised interviewers to encourage women who appeared to be distressed during the interview to call intervention organizations before leaving (Kallstrom-Fuqua et al., 2004).
RESULTS

Attrition Analysis

An attrition analysis was conducted to determine whether there were any significant differences between those women who completed interviews at both Waves 1 and 3 and those who did not. Women were compared on the following demographic variables: ethnicity, age, years of education, whether they were educated in the United States and number of years spent living in the Dallas area. Of the 835 women who completed the Time 1 interview, 176 (21.1%) women did not complete the interview at Time 3. There were significant differences in attrition between ethnicity groups ($\chi^2(2) = 15.483, p = .000$) with more European Americans dropping out than African American or Hispanic participants. There was no significant difference in attrition based upon whether or not the participants were born in the United States ($\chi^2(1) = 1.595, p = .207$). A MANOVA was conducted to examine the relation between the remaining demographic variables and attrition. There were no significant multivariate or univariate main effects indicating that rate of attrition was not significantly related to participants’ ages, years of education, or number of years living in Dallas. A second MANOVA was conducted to analyze whether there were significant differences between attrition groups on measures of interpersonal violence. Intimate partner violence variables were collapsed into three variables: mean threat of violence, physical aggression and sexual aggression. There was a significant multivariate main effect, Pillai’s trace $F(3, 831) = 4.345, p = .005, \eta^2 = .015$ and univariate main effects for threats of violence, $F(1, 834) = 5.337, p = .021, \eta^2 = .006$, and physical violence, $F(1, 834) = 6.626, p = .010, \eta^2 = .008$. Women who completed both waves of interviews reported fewer incidents of threats of violence and physical aggression ($M = .66, SD = .83; M = .36, SD = .59$) than women who did not complete interviews at wave three ($M = .83, SD = .93; M = .50, SD = .77$). Thus, the
women in the subsequent analyses may not have partner violence histories quite as severe as those who dropped out. However, given the small effect sizes, these differences are not likely to have much practical meaning.

Descriptive Statistics

Data was analyzed using SPSS 17.0 for Windows (SPSS Inc. 2009) and AMOS 17.0 for Windows (Arbuckle, 2008). Five participants were omitted from the analyses due to incomplete data on most measures. No data were missing once these participants were excluded from the study. Consistent with previous research using this dataset, highly kurtotic indicators, number of assaults and number of perpetrators, were trimmed to the fourth standard deviation beyond the mean rather than deleting outlier cases in order to reflect the true experiences of some women who were sexually assaulted as children numerous times or by a more than one perpetrator (Kallstrom-Fuqua et al., 2004). Two categorical indicators, father figure and parental alcohol/drug use, were also included within the model. Of the 178 participants, 134 (75%) reported being sexually abused by a non-father figure, as opposed to 44 (25%) individuals who reported that they had been abused by a father figure. 103 (58%) believed that one or both parents had a drinking or drug problem. Seventy-five (42%) individuals were either unsure or believed that their parents had no such problems. Means, standard deviations, and Cronbach’s alphas of continuous variables are presented in Table 1.

Table 1

*Descriptive Statistics for Continuous Indicators (N=178)*

<table>
<thead>
<tr>
<th>Indicators</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Childhood sexual abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of assaults (a)</td>
<td>18.37</td>
<td>36.19</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 1 (continued).

<table>
<thead>
<tr>
<th>Indicators</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of perpetrators&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1.88</td>
<td>1.38</td>
</tr>
<tr>
<td>Age at first assault</td>
<td>9.18</td>
<td>3.96</td>
</tr>
<tr>
<td>Nonsexual child abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychological aggression</td>
<td>2.05</td>
<td>1.66</td>
</tr>
<tr>
<td>Minor aggression</td>
<td>1.58</td>
<td>1.57</td>
</tr>
<tr>
<td>Severe aggression</td>
<td>1.12</td>
<td>1.08</td>
</tr>
<tr>
<td>Family Functioning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative messages</td>
<td>3.18</td>
<td>.85</td>
</tr>
<tr>
<td>Number of traumatic events</td>
<td>5.89</td>
<td>2.68</td>
</tr>
<tr>
<td>Psychological distress</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Drinks</td>
<td>2.73</td>
<td>3.23</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.94</td>
<td>.87</td>
</tr>
<tr>
<td>Posttraumatic stress disorder</td>
<td>.92</td>
<td>.77</td>
</tr>
<tr>
<td>Dissociation</td>
<td>.82</td>
<td>.79</td>
</tr>
<tr>
<td>Somatization</td>
<td>1.10</td>
<td>.84</td>
</tr>
<tr>
<td>General Distress</td>
<td>.99</td>
<td>.77</td>
</tr>
<tr>
<td>Revictimization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Threats of violence</td>
<td>.53</td>
<td>.65</td>
</tr>
<tr>
<td>Physical aggression</td>
<td>.45</td>
<td>.62</td>
</tr>
<tr>
<td>Sexual aggression</td>
<td>.36</td>
<td>.72</td>
</tr>
<tr>
<td>Rape</td>
<td>1.63</td>
<td>.30</td>
</tr>
</tbody>
</table>

*Note.* <sup>a</sup>Data have been trimmed. Number of assaults, number of perpetrators, age at first assault, and number of drinks are single item indicators.

Correlations between indicators and their respective latent variables are presented in tables 2-6.

Table 2

*Intercorrelations among Child Sexual Abuse Indicators (N=178)*

<table>
<thead>
<tr>
<th></th>
<th>Father Figure</th>
<th># of Assaults</th>
<th># of Perpetrators</th>
<th>Age at First Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father Figure</td>
<td>(-)</td>
<td>.37**</td>
<td>.14</td>
<td>-.21**</td>
</tr>
<tr>
<td># of Assaults</td>
<td>(-)</td>
<td>.25**</td>
<td></td>
<td>-.32**</td>
</tr>
<tr>
<td># of Perps</td>
<td>(-)</td>
<td></td>
<td></td>
<td>-.22**</td>
</tr>
</tbody>
</table>

*(table continues)*
Table 2 (continued).

<table>
<thead>
<tr>
<th>Father Figure</th>
<th># of Assaults</th>
<th># of Perpetrators</th>
<th>Age at First Assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>(--)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. **Correlation is significant at the .01 level (2-tailed). (--) alpha coefficient could not be computed because indicator is a single item.*

Table 3

*Intercorrelations among Nonsexual Child Abuse Indicators (N=178)*

<table>
<thead>
<tr>
<th>Psychological Aggression</th>
<th>Minor Aggression</th>
<th>Severe Aggression</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psych Aggress.</td>
<td>(.76)</td>
<td>.75**</td>
</tr>
<tr>
<td>Minor Aggress.</td>
<td></td>
<td>(.82)</td>
</tr>
<tr>
<td>Severe Aggress</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. **Correlation is significant at the .01 level (2-tailed). ( ) = alpha coefficient.*

Table 4

*Intercorrelations among Family Functioning Indicators (N=178)*

<table>
<thead>
<tr>
<th>Negative Messages</th>
<th># of Traumatic Events</th>
<th>Parent Drinking/Drug Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative Mssg.</td>
<td>(.76)</td>
<td>.01</td>
</tr>
<tr>
<td># Traumatic Events</td>
<td></td>
<td>(.72)</td>
</tr>
<tr>
<td>Parent Drink/Drug</td>
<td></td>
<td>(--)</td>
</tr>
</tbody>
</table>

*Note. ( ) = alpha coefficient. (--) alpha coefficient could not be computed because indicator is a single item.*
Table 5

*Intercorrelations among Psychological Distress Indicators (N=178)*

<table>
<thead>
<tr>
<th></th>
<th>Alcohol Use</th>
<th>PTSD</th>
<th>Somatization</th>
<th>Dissociation</th>
<th>Anxiety</th>
<th>SCL Global</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Use</td>
<td>(--)</td>
<td>.001</td>
<td>-.14</td>
<td>.04</td>
<td>.01</td>
<td>.000</td>
</tr>
<tr>
<td>PTSD</td>
<td>(.95)</td>
<td>.81**</td>
<td>.92**</td>
<td>.93**</td>
<td>.98**</td>
<td></td>
</tr>
<tr>
<td>Somatization</td>
<td>(.90)</td>
<td>.70**</td>
<td>.76**</td>
<td>.82**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dissociation</td>
<td>(.93)</td>
<td></td>
<td>.85**</td>
<td>.89**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>(.93)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.93**</td>
</tr>
<tr>
<td>General Distress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(.98)</td>
</tr>
</tbody>
</table>

*Note.* **Correlation is significant at the .01 level (2-tailed). ( ) = alpha coefficient. (--) alpha coefficient could not be computed because indicator is a single item.

Table 6

*Intercorrelations among Revictimization Indicators (N=178)*

<table>
<thead>
<tr>
<th></th>
<th>Threats</th>
<th>Physical Aggression</th>
<th>Sexual Aggression</th>
<th>Rape</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats</td>
<td>(.94)</td>
<td>.99**</td>
<td>.52**</td>
<td>.03</td>
</tr>
<tr>
<td>Physical Aggress.</td>
<td>(.94)</td>
<td></td>
<td>.52**</td>
<td>.03</td>
</tr>
<tr>
<td>Sexual Aggress.</td>
<td></td>
<td>(.85)</td>
<td></td>
<td>.11</td>
</tr>
<tr>
<td>Rape</td>
<td></td>
<td></td>
<td></td>
<td>(.66)</td>
</tr>
</tbody>
</table>

*Note.* **Correlation is significant at the .01 level (2-tailed). ( ) = alpha coefficient.

Group Comparisons

A MANOVA was conducted to compare the 178 remaining subjects by ethnic group on the indicators of the latent variables of the structural model: revictimization, child sexual abuse, psychological abuse, and non sexual child maltreatment. There were no significant multivariate or univariate main effects for child sexual abuse, nonsexual child maltreatment or psychological
distress variables. There was no significant multivariate effect for revictimization; however, there were significant univariate main effects for threats of violence, $F(2) = 3.324, p = .038, \eta^2 = .037$ and physical aggression, $F(2) = 3.646, p = .028, \eta^2 = .040$. African American women experienced more threats of violence ($M = .70, SD = .85$) and more physical aggression ($M = .62, SD = .82$) than Hispanic and European American women. European American women experienced more threats of violence ($M = .48, SD = .58$) and physical aggression ($M = .41, SD = .55$) than Hispanic women ($M = .40, SD = .41$, $M = .32, SD = .37$, respectively). These differences may not be meaningful given the small effect sizes.

Structural Equation Modeling

Structural equation modeling (SEM) was used to determine the viability of the proposed models. Structural equation modeling is a statistical technique that determines how well data fit a proposed theoretical model. There are two types of variables in SEM. The first is a latent construct. A latent construct is a variable that cannot be observed and can only be learned about through observed indicators. Latent constructs are estimated by measuring the other type of SEM variable: observed indicators. Observed indicators for a given latent construct should be intercorrelated to ensure that they are reflective of the underlying latent construct. The amount of measurement error for each observed indicator is also considered in SEM in order to determine the extent to which the observed indicator is measuring something other than the latent construct (Schumacker and Lomax, 2004).

There are a number of advantages to using SEM. First, SEM allows the researcher to study numerous variables at once and determine how they interrelate. SEM also accounts for measurement error. All observed indicators of a latent construct are composed of true score and
**Confirmatory Factor Analysis**

Confirmatory factor analysis (CFA) determines the fit of the measurement model to the data prior to testing the structural model. CFA ensures that the indicators accurately measure the latent variables and that the indicators represent a unitary construct. Goodness of fit was evaluated using the normed chi-square ($X^2/df$), comparative fit index (CFI), Tucker-Lewis index (TLI), incremental fit index (IFI), and root-mean-square error of approximation (RMSEA). $X^2/df$ was used as an overall model of fit because while still highly influenced by sample size, it is less so than the model chi-square ($X_M^2$) (Kline, 2005). An $X^2/df$ less than three is indicative of a good fit. The CFI, TLI, IFI and RMSEA are well-established measures of fit that are less sensitive to the influence of small sample size. CFI, TLI and IFI values of .97 are suggestive of good model fits and values of .95 are considered an adequate fit. An RMSEA of .08 to .06 suggest an adequate fit, and values between .05 and 0 are considered to be a good fit (Schermelleh-Engel & Moosbruger, 2003).

**Measurement Model**

All latent variables were allowed to covary with one another and observed indicators were restricted to loading onto their respective factors. Initial fit was poor ($X^2 = 169.26, X^2/df = 1.53, p = .000; CFI = .961, TLI = .941, IFI = .962, and RMSEA = .054$). The three indicators for family functioning: negative messages, number of traumatic events, and parental alcohol/substance problems had small factor loadings with StdYX values of .03, -.008, and .05 respectively. The indicators accounted for a small amount of the variance and had large standard errors, as well as weak interrcorrelations. Therefore, it was determined that the indicators did not...
adequately measure the latent variable and family functioning was removed from the measurement model. Factor loadings were also small for one indicator of the latent variable psychological distress, number of drinks (StdYX = .08) and was removed from the model as well. Assessed model fit continued to be problematic ($X^2 = 187.278, df = 98, p = .000; CFI = .954, TLI = .943, IFI = .95, RMSEA = .072$). One indicator for the latent variable revictimization, rape, had a small factor loading with a value of .04 and was removed from the model. The respecified model was again tested and was shown to have an improved fit ($X^2 = 93.102, df = 71, p = .040; CFI = .990, TLI = .987, IFI = .990, RMSEA = .042$). Upon final inspection of the correlation matrix, a high univariate correlation between threats of violence and physical aggression suggested possible redundancy ($r = .997$). Therefore, threats of violence was removed from the model. Many indicators of psychological distress were also highly correlated but remained in the model because of their high degree of comorbidity (American Psychological Association, 2000). The model was respecified and after the removal of mean threat of IPV, and the model’s fit further improved ($X^2 = 83.93, df = 71, p = .14; CFI = .99, TLI = .99, IFI = .99, RMSEA = .03$) and was a good fit. The final factor loadings of the indicators on their respective latent variables are presented in Table 7.

Table 7

*Factor Loadings of Indicators on Latent Variables (N=178)*

<table>
<thead>
<tr>
<th>StdYX</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Childhood Sexual Abuse</strong></td>
<td></td>
</tr>
<tr>
<td>Father figure</td>
<td>48</td>
</tr>
<tr>
<td># Assaults</td>
<td>.79</td>
</tr>
<tr>
<td># Perpetrators</td>
<td>.32</td>
</tr>
<tr>
<td>Age at first Assault</td>
<td>-.43</td>
</tr>
<tr>
<td><strong>Nonsexual Child Abuse</strong></td>
<td></td>
</tr>
</tbody>
</table>

*(table continues)*
Structural Models

The fit of two structural models were compared: (A) a direct effects model in which CSA and nonsexual child maltreatment predicted psychological distress; and (B) an indirect effects model in which psychological distress was proposed to mediate the relation between childhood sexual and nonsexual victimization and adult revictimization. In the direct effects model, significant pathways were identified between non-sexual child maltreatment and psychological distress and between non-sexual child maltreatment and revictimization. Pathways were nonsignificant from CSA to psychological distress and from CSA to revictimization. Figure 3 presents the standardized path coefficients of the direct model. In the indirect model, significant paths from non-sexual child maltreatment to psychological distress, and from psychological distress to revictimization were identified. See Figure 4 for the standardized path coefficients of
the indirect model. Literature on structural equation modeling encourages the testing of all potentially viable alternative models (Kline, 2005). A third model was tested with revictimization mediating the relation between nonsexual child abuse and CSA and revictimization. The path from CSA to revictimization continued to be insignificant; however, significant paths from nonsexual child abuse to revictimization and from revictimization to psychological distress were identified. Figure 5 presents the standardized path coefficients of this second indirect model. Goodness-of-fit indices indicated a good fit for both indirect models (See Table 8).

Table 8

<table>
<thead>
<tr>
<th>Model</th>
<th>X²</th>
<th>df</th>
<th>X²/df</th>
<th>TLI</th>
<th>IFI</th>
<th>CFI</th>
<th>RMSEA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct effects</td>
<td>94.17</td>
<td>72</td>
<td>1.31</td>
<td>.98</td>
<td>.99</td>
<td>.99</td>
<td>.04</td>
</tr>
<tr>
<td>Indirect effects 1</td>
<td>84.48</td>
<td>73</td>
<td>1.23</td>
<td>.99</td>
<td>.99</td>
<td>.99</td>
<td>.04</td>
</tr>
<tr>
<td>Indirect effects 2</td>
<td>85.44</td>
<td>73</td>
<td>1.17</td>
<td>.99</td>
<td>.99</td>
<td>.99</td>
<td>.03</td>
</tr>
</tbody>
</table>

Note. Indirect effects 1 = CSA/CTS → psychological distress → revictimization. Indirect effects 2 = CSA/CTS → revictimization → psychological distress. TLI = Tucker-Lewis index; IFI = incremental fit index; CFI = comparative fit index; RMSEA = root-mean-square error of approximation.
Figure 3. The final structural direct effects model. Nonsx CA = nonsexual child abuse; Psy. Distress = psychological distress; Revictim. = revictimization. *p < .05. **p < .01.

Figure 4. The final structural indirect effects model with psychological distress as a partial mediator. Nonsx CA = nonsexual child abuse; Psy Distress = psychological distress; Revictim = revictimization. *p < .05.
Baron and Kenny (1986) suggest four steps to determine whether a variable is a mediator. They suggest conducting three simple regression analyses to determine whether zero order relations exist among the variables. A simple regression analysis was conducted with nonsexual child abuse predicting revictimization (in the indirect model depicted in Figure 4). The result was significant ($B = .15, p = .006$). Results were also significant for a second simple regression analysis was conducted with nonsexual child abuse predicting psychological distress ($B = .13, p = .04$). The third simple regression analysis was also significant with psychological distress predicting revictimization ($B = .13, p = .03$). A multiple regression analysis was conducted for the fourth test of mediation in which both nonsexual child abuse and psychological distress predict revictimization. Because nonsexual child abuse remained a significant predictor of revictimization ($B = .09, p = .04$), as did psychological distress ($B = .14, p = .008$), psychological distress was determined to only partially mediate the relation between nonsexual child abuse and revictimization suggesting that the path from nonsexual child abuse to revictimization is reduced, but still significant when the mediator is controlled.
The same steps were used to determine whether revictimization mediated the relationship between nonsexual childhood abuse and psychological distress. A simple regression analysis was conducted with nonsexual child abuse predicting psychological distress (the indirect model depicted in figure 5). The result was significant ($B = .13, p = .04$). Results were also significant for a second simple regression analysis was conducted with nonsexual child abuse predicting revictimization ($B = .15, p = .006$). The third simple regression analysis was also significant with revictimization predicting psychological distress ($B = .64, p = .001$). A multiple regression analysis was conducted for the fourth test of mediation in which both nonsexual child abuse and revictimization predict psychological distress. Nonsexual child abuse did not remain a significant predictor of psychological distress ($B = .07, p = .26$). The association between revictimization and psychological distress remained significant ($B = .56, p = .002$), suggesting that revictimization fully mediates the relation between nonsexual maltreatment and psychological distress.

A parsimony fit index was used to determine the better fitting of the three models. The parsimony normed fit index (PNFI) with the higher value indicates the better fit while the Akaike Information Criterion (AIC) considers the model with the minimum AIC value to be the better fit (Schermellah-Engel & Moosbruger, 2003). The indices suggested that the alternative indirect model (Figure 5) was a better fit (PNFI = .768; AIC = 177.44) than the proposed indirect model (Figure 4; PNFI = .766; AIC = 181.48) and the direct model (PNFI = .754 AIC = 188.17).
DISCUSSION

Three models were analyzed in the present study that sought to identify factors associated with childhood sexual abuse that increase a woman’s risk for adult physical and sexual revictimization. The first model proposed that childhood sexual abuse, negative family functioning and nonsexual child abuse would directly affect psychological distress and indirectly predict adult revictimization. The second model proposed that characteristics of childhood sexual abuse, negative family functioning and nonsexual child abuse would directly predict psychological distress, as well as revictimization. The hypothesized relations among variables were revised after indicators for the latent variable family functioning proved to have small factor loadings and weak intercorrelations suggesting that they did not adequately reflect the latent variable. As such, they were omitted from the model, thus eliminating this study’s ability to test negative family functioning as a latent variable in the final data analysis.

Testing the first model analysis only partially supported the research hypothesis. In this sample, CSA does not appear to have an indirect impact on revictimization through psychological distress. However, the hypothesis that nonsexual child abuse directly predicts psychological distress and indirectly predicts revictimization was supported. Psychological distress appears to partially mediate the relation between nonsexual maltreatment and revictimization. This suggests that experiencing nonsexual abuse is a risk factor for revictimization regardless of the level of psychological distress. A similar pattern emerged from testing the direct effects model. Childhood sexual abuse characteristics do not appear to predict psychological distress or revictimization. On the other hand, nonsexual childhood abuse directly predicts psychological distress and revictimization.
These findings summarized above support past research by Arata and Lindman (2002) in which a history of child physical abuse was found to be a predictor of revictimization. All women included in the present study experienced a history of childhood sexual abuse, but it was the combination of being sexually abused in addition to experiencing a form of nonsexual abuse as well that predicted revictimization. These findings are consistent with past research by Messman-Moore and Brown (2004). They found that experiencing child sexual abuse put persons at risk for revictimization. However, experiencing more than one type of abuse increased the risk substantially, suggesting that it is the cumulative effect of childhood trauma that is most predictive of adult victimization.

The present study did not find that being a survivor of childhood sexual abuse alone predicted adult psychological distress, specifically symptoms related to somatization, anxiety, dissociation, posttraumatic stress disorder and overall mental health. Past research has documented the psychological distress experienced by adults who experience sexual abuse (Bagley, 1996; Kendall-Tackett, 2003; Lang et al., 2004; Molnar, Berkman, & Buka, 2001; Molnar, Buka, & Kessler, 2001). Nonetheless, in the current sample, the cumulative effects of experiencing more than one type of abuse is a much more robust predictor of later psychological maladjustment. Bagley (1996) found that childhood sexual abuse was a significant but weak predictor of adult psychiatric problems. But, experiencing more than one type of abuse, especially emotional abuse, was a stronger predictor of maladjustment in adulthood. Lang et al (2004) also found that the cumulative experience of multiple forms of childhood maltreatment (rather than CSA alone) was a predictor of more severe psychological distress. Individuals who experienced child maltreatment were more likely to have PTSD, depression, anxiety, somatic complaints, eating disorders, substance abuse, personality disorders, and suicidal behavior as
adults (Arias, 2004). Therefore, for those who experienced multiple forms of child abuse, the cumulative effects of those experiences alone seem to be enough to continue to influence their adult psychological adjustment and risk for revictimization.

In women similar to those in the present study, experiencing childhood sexual abuse alone may not be directly related to psychological distress or revictimization. Instead, other factors or events not assessed in the present study may mediate the relations between childhood sexual abuse and adult maladjustment or revictimization. For example, past research has found that powerlessness and betrayal, variables included in Finkelhor and Brown’s (1985) Traumagenic Dynamics Model, mediated the relations between child sexual abuse and maladaptive relationships and psychological distress (Kallstron-Fuqua et al, 2004). Other studies have found that avoidant coping strategies, risky sexual behavior and substance use are predictive of adult sexual revictimization in survivors of childhood sexual abuse (Arata, 2000).

Kline (2005) suggests that one of the final steps to structural equation modeling is to ensure that all potentially equivalent models have been considered. Thus, a third model was developed and tested as a potential alternative to better explain the relations among CSA, nonsexual child abuse and revictimization. This model proved to be the best fit for the present data. Consistent with the previously discussed models in the present study, child sexual abuse alone did not predict revictimization, nor did it have an indirect effect on adult psychological distress. Previous literature has found an association between CSA and adult revictimization; however, as stated previously, there are likely other mediating factors that increase the risk of revictimization and adult psychological distress.

Consistent with the third model, revictimization may fully mediate the relation between experiencing more than one type of childhood abuse and psychological distress in women similar
to the present sample. Experiencing both sexual and nonsexual abuse in childhood directly predicts being revictimized as an adult in an abusive interpersonal relationship. Some past research supports this model. Arias (2004) found that children who have been abused are at risk for physically and sexually abusive interpersonal relationships as adults. The third model suggests that without revictimization, the relation between experiencing child abuse (sexual and nonsexual) and psychological distress becomes weak. Revictimization, rather than abuse experienced in childhood, predicts psychological distress in these women. This is also supported by past research. Classen et al. (2005) found that revictimized women suffered more psychological distress than women who were victimized only once. Revictimized women were more likely to experience major depressive episodes, dysthymia, PTSD, and anxiety disorders, such as simple phobia and social phobia, as well as higher incidences of dissociation and alcohol and drug dependence. Similarly, Arias (2004) found that revictimized women are also more likely to have more somatic complaints than women who were never victimized or experienced only one incident of victimization in adulthood.

Clinical Implications

The results of the present study underscore the importance of recognizing the extremely negative impact of multiple forms of child abuse and the increased risk of being revictimized within an adult interpersonal relationship. Previous researchers have suggested that children who are abused become wary of others and develop a belief that violence is a normal part of relationships, coming to expect it within their own adult interpersonal relationships (Arias, 2004). As such, it is important for social workers, therapists and other mental health providers to identify children who have experienced multiple forms of child maltreatment and provide interventions. Effective interventions would likely target their beliefs about relationships,
educate them about choosing healthy relationships, and find ways to increase their levels of self-esteem and interpersonal effectiveness. These interventions could be delivered in either a group or individual format. There might be some advantages to group interventions; a group therapy can allow children to learn from one another and practice newly learned skills. This type of psychoeducational group could be delivered to a variety of ages and tailored accordingly for each developmental stage. Important skills for children and adolescents to develop would include appropriate communication and conflict resolution skills. Assertiveness, self-esteem building and boundary setting would also be an important focus, as well as signs to look for in relationships that could be indicative that the relationship is at risk for becoming abusive, such as identifying early signs of power and control that might be missed by victims of interpersonal violence.

The present study also highlights the importance of treatment for women with a history of childhood abuse that were not identified early on and have already been revictimized. Medical providers, social services workers, and mental health staff who work with victimized women should gather a thorough childhood history and inquire about multiple forms of abuse they might have experienced. Skill building and education about healthy relationships can be important interventions for revictimized women. However, it may also be necessary for these women to explore the connections between childhood abuse and their beliefs about themselves and others, and to process negative emotions related to their childhood pain. Foa and Rothbaum (2001) suggest that two beliefs, or “schemas”, are at the core of psychological distress experienced by adult women who are assaulted. The first belief is in regards to personal competence (“I am incompetent”) and the second is about the relative safety or dangerousness of the world (“The world is a dangerous place.”). They assert that for children who were traumatized, these negative beliefs about self-efficacy and the dangerousness of their world may already be well ingrained
and rigid by adulthood and are merely reinforced by the subsequent victimization. Identifying these rigid “schemas” as well as other negative or distorted beliefs that result in emotional maladjustment them may help to reduce psychological distress experienced by these revictimized women, and decrease their risk for future interpersonal violence.

In regards to women who experienced childhood sexual abuse alone, results of the present study did not suggest a direct link between childhood sexual abuse and revictimization or psychological distress. This is a good reminder for mental health workers that resilience is common (Bonnano, 2004) and many traumatized persons never need therapy. However, it remains possible that other factors mediate the connection between CSA and revictimization. For example, past research (Arata, 2000) suggests that past CSA survivors who use substances and drink alcohol heavily are at greater risk for revictimization. Poor family functioning (which was not directly assessed in the present study) may also put survivors at risk (Kendall-Tackett, 2003). Addressing such potential mediating factors in women who have a history of CSA might reduce the risk for future victimization.

Limitations

There are a number of limitations to the present study. First, this study used retrospective reports of childhood abuse by adult women. As such, memories may not be completely accurate and may be subject to some distortion. Also, due to the cross-sectional nature of this study, causality cannot be inferred.

Because this study used an existing data set, the indicators available to reflect latent variables were limited. The indicators available for family functioning did not reflect a unitary construct; family functioning had to be omitted from the study as there were no other possible indicators to choose from that might adequately reflect the latent variable. As a result, this study
was limited in the investigation of factors that could contribute to the understanding of the relation between childhood abuse and revictimization. Other available scales, such as the rape scale, had few items and low reliability and were therefore excluded as indicators, thus limiting the types of revictimization that could be examined in the present study. Only interpersonal physical and sexual violence were addressed, and no relations between the exogenous variables and unwanted sexual contact by a stranger could be established.

The need to use single item indicators also poses some problems. The indicators for the latent variable childhood sexual abuse, participant’s alcohol/drug use, and parental substance use were single item indicators (i.e., not part of a scale). Using single items rather than a scaled score typically decreases reliability and the magnitude of factor loadings. As a result, there is often a decreased chance of finding meaningful direct and indirect relations as predicted. Thus, the connections among childhood sexual abuse, psychological distress, and revictimization may have been suppressed given the inherent weakness of using single item indicators used to reflect the latent constructs.

In addition to having to choose indicators that were not developed with the present study in mind, but that would most closely reflect the given latent constructs within the existing data set, missing data also limited which measures could be used as indicators. For example, a single item measure of parental substance use was chosen because a more reliable measure was missing most of its data. Again, this circumstance prevented the present study from being able to more thoroughly account for factors that may play an important role in risk for revictimization.

In regards to methodological limitations, on the measures of psychological distress, there is some symptom overlap amongst scales, which increases collinearity and could potentially limit the generalizability of the findings. In addition, most research on child sexual abuse uses a
five-year age gap between perpetrator and victim as part of the definition of child sexual abuse. In the present study, incidents of sexual abuse were reported by age of occurrence; there were no questions that asked for the age of the perpetrator except in items regarding touching or fondling by an adult. Therefore, it was not possible to identify a five-year age difference between victim and perpetrator. Thus, it is possible that incidents perpetrated by a peer were included as child sexual abuse in the present study. The current study also defined sexual abuse as sexual contact from 0-18 years old. There are mixed opinions in the literature about using such a broad age range, with some researchers expressing concern that the lack of consensus contributes to child sexual abuse being a poorly defined construct with variable prevalence rates (Arata, 2002; Pilkington & Kramer, 2006).

Finally, the sample size of the present study might also be considered a limitation. Research is mixed regarding what is considered an adequate sized sample for structural equation modeling with recommendations ranging between 150-5000 participants, depending on the model to be analyzed (Schermelleh-Engel et.al, 2003). Although the present sample size is considered adequate given the number of parameters in the model, a larger sample would have increased the likelihood of identifying additional meaningful relations among variables (Kline, 2005).

Directions for Future Research

It would be beneficial for future research to identify factors that mediate the relation between CSA and revictimization. Determining these factors would allow individuals who work with survivors to intervene in appropriate areas to reduce the risk of further victimization and subsequent emotional distress. It would also be beneficial to study not only factors that increase risk for victimization, but also protective factors that buffer the effects of childhood abuse, both
CSA alone and multiple forms of child maltreatment. With such knowledge, interventions could be targeted to dramatically reduce the risk of revictimization.

Future studies could examine the efficacy of interventions delivered to identified survivors of child abuse. Group interventions that focus on education regarding healthy relationships and skill building appear particularly relevant. Researchers should conduct treatment outcome studies for different age groups and assess participants’ attitudes about relationships, as well as beliefs about self and others, pre- and post-treatment. Child abuse survivors could be randomly assigned to either the experiment group or a control group that would be a general process group. The experimental group would receive group therapy focused on healthy relationships and psychoeducation to increase skills in assertiveness, communication, conflict resolution, and boundary setting. Beliefs related to self-esteem, competency, and trust could also be explored, as well as the processing painful emotions associated with being a survivor of child abuse. Ideally, these children would be followed into young adulthood and adulthood. Psychological distress and level of violence within their relationships would be assessed to determine whether the group therapy significantly reduced their risk for interpersonal violence and emotional maladjustment. The rate of revictimization as well as level of psychological distress between the two groups would be compared. It would be expected that the group who received psychoeducation, skill building, and cognitive behavioral therapy aimed at identifying and challenging negative beliefs about self and others would have significantly less incidence of adult interpersonal violence and less psychological distress than their counterparts who participated in the process group.

Beneficial research might also examine the effects of intervening with not only children who experienced multiple forms of abuse, but also with the non-offending or rehabilitated
parents. Past research has suggested that in families where abuse has occurred, the rest of the non-offending family members are experiencing difficulties as well (Gil, 1991). Additionally working with the family, rather than the abused child as the identified patient, may increase the likelihood that work in therapy can be generalized to the home environment and the family will not try to sabotage change for the sake of maintaining a dysfunctional homeostasis. A study could examine whether interventions geared towards teaching the parents of abused children appropriate parenting skills, as well as relationship skills, could serve to model healthy relationships and decrease the likelihood children would engage in behavior that might increase their risk for revictimization. At later follow-up with these children as young adults/adults they could be compared with a separate group of individuals with a history of child abuse whose parents did not participate in any interventions to determine whether there are significant differences between rates of revictimization and psychological distress.

Finally, it may be beneficial to examine the reasons why the cumulative effects of child abuse have a stronger and more direct relation with revictimization and indirectly with increased psychological distress than child sexual abuse alone. The examination of internal factors, such as their perceptions of self and others, as well as environmental factors, such as family functioning, may provide some insight into the different paths that lead to revictimization so that appropriate interventions can be developed and implemented.

Conclusions

The present study was one of only a few to use a sample of community women to study the relations between childhood sexual abuse and adult revictimization. Women who experienced child physical and psychological abuse in addition to sexual abuse were also included. Experiencing multiple forms of childhood maltreatment appears directly related to
revictimization in the form of physical and sexual interpersonal violence, and indirectly related to psychological abuse. There may be other mediating factors beyond the scope of the present study that increase psychological distress and risk of adult revictimization when a child experiences CSA alone.

One important implication of the current findings involves early intervention. Intervening directly with children who have experience multiple forms of abuse may be critical for decreasing their risk of physical and sexual revictimization and the psychological distress associated with being a victim of interpersonal violence as an adult.
REFERENCES


