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Predicting sexual revictimization : An examination of dissociation alexithymia alcohol use and loneliness

Linda M. Frey

The University of Montana

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PREDICTING SEXUAL REVICTIMIZATION:
AN EXAMINATION OF DISSOCIATION, ALEXITHYMIA,
ALCOHOL USE, AND LONELINESS

by

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Master of Arts

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Predicting Revictimization: An Examination of Dissociation, Alexithymia, Alcohol Use, and Loneliness

Director: Jennifer Waltz, Ph.D.

Research to date has found that women who experience childhood sexual abuse (CSA) are 2 to 2.5 times more likely than those who do not to be sexually assaulted in adulthood (revictimized). Most investigations that have attempted to identify mechanisms for this higher incidence of victimization have been cross-sectional, making interpretation of group differences difficult. In an attempt to address this weakness, the current study employed a prospective design to examine the roles of dissociation, alexithymia, alcohol use, and loneliness as possible risk factors for sexual revictimization.

Participants were 338 female students enrolled in the introductory psychology course at the University of Montana. At the beginning of the semester, each completed a number of measures designed to assess sexual victimization history, levels of dissociation and alexithymia, alcohol use, and degree of loneliness. Participants returned nine weeks later to complete another set of measures. In addition to repeating the prediction measures, data were also collected concerning sexual victimization occurring during the interim period. Ninety-two (27.5%) of the participants endorsed a history of CSA. A total of 10.4% of participants (35) reported experiencing some form of sexual victimization during the course of the study. Consistent with other research, CSA survivors had a greater rate of victimization than non-CSA survivors (19.6% compared to 7.7%). A logistic regression analysis using CSA survivors was carried out entering the four independent variables simultaneously. None of the constructs examined were significant in this analysis. An additional logistic regression analysis was also conducted using the entire sample. This second logistic regression included childhood sexual abuse status as another independent variable. In this analysis, both CSA and alexithymia were significant predictors of sexual victimization; further, alexithymia accounted for greater than twice the variance that was accounted for by CSA ($r=.17$, $r= -.10$, respectively). Implications of these results for both prediction and prevention efforts are discussed.
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Introduction

The sexual victimization of women and children has occurred since time immemorial. Historically, both groups have been regarded as chattel with neither societal pressure nor legal recourse afforded for their protection. Gradually, however, attitudes have changed. In the latter part of the 20th century, western society came to view the exploitation and victimization of women and children not only as morally and legally wrong but also markedly harmful. As a result, difficulties surrounding victimization have become a focus of concern and scientists are now directing their efforts towards greater understanding of this societal problem. In response, two lines of research have developed: one that focuses on childhood sexual abuse (CSA) and the other which focuses on adult sexual victimization. Both of these research areas have identified numerous sequellae associated with sexual victimization. We begin with a discussion of the literature specific to CSA.

Childhood Sexual Abuse

CSA can be defined as any sexual behavior that is forced or coerced on a child, or any sexual behavior regardless of coerciveness, between a child and a much older person (Browne & Finkelhor, 1986); the age difference generally utilized for this latter distinction being five years. CSA is commonly defined as the above behavior occurring before the age of 14. However, investigations of CSA have employed age criteria ranging from 13 to 18 years. Generally, collapsing what may be identified as CSA and adolescent sexual victimization together when including the upper age ranges.

Regardless, the incidence and prevalence of childhood sexual abuse is
considerable. In 1996, there were 218,820 children reported sexually abused in the United States (Child Abuse Council, 1998). Reported instances of sexual abuse, however, are recognized as an underrepresentation of true incidence. Hence, researchers have employed retrospective reports from adult samples to gain further information.

Investigating such reports of adult women, researchers have found a significant percentage to endorse a history of CSA. Using random community sampling, Bagley and Ramsay found 22% of women had experienced “serious, unwanted sexual assault, involving at least manual interference with their genital area” before the age of 16 (1986, p. 33). In a review of the literature, Finkelhor (1994) found rates of CSA among females to vary between 7 and 36 percent while rates among males varied between 3 and 29 percent. Clearly, CSA is not an isolated problem impacting small numbers of individuals, it occurs in epidemic proportions. But to what end?

Once researchers began investigating issues surrounding the sexual abuse of children, it was found that victims of CSA often experience numerous difficulties in adulthood (e.g., Bagley & Ramsay, 1986; Brown & Finkelhor, 1986; Peters, 1988). Such difficulties can be loosely organized within the following categories: psychological challenges, adverse behavioral or physiological manifestations, interpersonal challenges or distinctions, and circumstantial proclivities. Table 1 summarizes the findings in each of these categories, while a detailed discussion follows.

Insert Table 1
Psychological Challenges

Adult survivors of CSA have been shown to face a wide array of psychological difficulties including an increased prevalence of psychiatric diagnoses involving mood, anxiety, and substance-related disorders. While there has been some recent challenge (Rind, Tromovitch, & Bauserman, 1998) suggesting that not all survivors are affected in a significant manner, the bulk of the data indicate that most survivors suffer some psychological consequence as a result of their abuse. General characteristics often reported among CSA survivors include low self-esteem, depression, harmful thoughts and behaviors, guilt, fears, and difficulties with concentration (e.g., Hulme & Grove, 1994; Sedney & Brooks, 1984; Collings, 1997). Although such challenges are not solely relegated to CSA survivors, they are reported in higher frequency within this population.

In their study limited to CSA survivors, Hulme & Grove (1994) report a high incidence of depression, guilt, low self-esteem, mood swings, phobias, confusion, flashbacks, extreme anger, lapses in memory, and suicidal thoughts. Also using a clinical sample, Briere and Runtz (1987) found women reporting a history of CSA evidenced increased levels of dissociation, tension, and anger when compared to women who did not report a CSA history.

Psychological challenges, however, are not confined to clinical samples. In a comparative study of college women, Sedney & Brooks (1984) found self-injurious thought, nervousness/anxiety, thoughts of harming others, and learning problems more prevalent among those women reporting a history of early sexual experiences. Briere and Runtz (1988) found university women with a CSA history reported significantly higher
levels of dissociation, somatization, anxiety, and depression compared to women reporting no CSA history. In their random university sample, Bendixen, Muus, and Schei (1994) found greater levels of anxiety, depression, feelings of shame and guilt, and more frequent suicidal ideation among women CSA survivors.

And, using the Brief Symptom Inventory with a university sample, Collings (1997) found significantly higher levels of somatization, obsessive-compulsive behaviors, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism for those women reporting a history of CSA compared to those not reporting such a history. Collings also reports significantly lower self-esteem and more frequent suicidal ideation within his survivor group.

Adverse symptomatology has also been found in community samples of survivors. Peters (1988) reports a significantly higher number of major depressive episodes amongst women reporting a history of physical contact sexual abuse than women reporting noncontact CSA or no abuse histories. Depression was also found to be more prevalent among Bagley and Ramsey's 1986 random community sample comparing women with a history of CSA to those without. In fact, these authors found women with a history of CSA to be twice as likely to evidence poor mental health compared to women without such a history. In addition to higher rates of depression, these women also reported significantly poorer self-esteem, higher levels of stress, greater depersonalization and dissociation, and had received significantly more psychiatric treatment within the last year.

Finally, using data collected from the Los Angeles Epidemiological Catchment
Area survey, Stein, Golding, Siegel, Burnam, and Sorenson (1988) report a higher lifetime prevalence among women with a history of CSA for the following diagnoses: alcohol abuse/dependence, drug abuse/dependence, affective disorders, major depressive disorder, anxiety disorders, phobias. Generally speaking, these women were significantly more likely to receive a psychiatric diagnosis than the non-survivor group.

**Adverse Behavioral or Physiological Manifestations**

Sequelae associated with CSA have also been found falling under the behavioral and physiological domains. Within the behavioral context significant difficulties have been reported associated with appetite, self-harm, promiscuity, and substance abuse (e.g., Bagley & Ramsay, 1986; Sedney & Brooks, 1984; Hulme & Grove, 1994; Romans, Martin, Anderson, O’Shea, & Mullen, 1995). Those difficulties reported within the physiological arena include sleep problems, headaches, and sexual dysfunction (e.g., Briere & Runtz, 1987; Hulme & Grove, 1994). Although in some cases, manifestations remain closely linked with sexuality and sexual behavior, this is not always the case.

Hulme and Grove (1994) report a number of behavioral/physiological symptomatology associated with CSA. These include insomnia, sexual dysfunction, over- and under-eating, drug and alcohol abuse, severe headaches, promiscuity, and attempted suicide. Sedney and Brooks (1984) report increased prevalence of alcoholism, drug overdoses, suicide attempts, and weight loss when comparing their early sexual experience subjects to a matched control group.

In a community-based study examining mediators between CSA and adult psychological outcome, Romans, Martin, Anderson, O’Shea, and Mullen (1995)
before the age of 13. During these interviews, the authors asked participants their opinions of the outcomes they had experienced as a result of the abuse. Behavioral or physiological difficulties these women ascribed to their abuse experiences included: sexual dysfunction, promiscuity, substance abuse, and specific fears. In addition, more of the CSA sample indicated a history of an eating disorder than the comparison group.

Bagley and Ramsay (1986) report a greater incidence of deliberate self-harm or suicide attempts among their CSA sample, while Briere and Runtz (1987) identified a higher incidence of sleep disturbance and sexual dysfunction within their clinical CSA sample. Peters (1988) reported women endorsing a history of contact CSA also experienced a greater frequency of alcohol abuse and probably drug abuse. Collings (1997) found lower levels of sexual adjustment within his student CSA sample. Finally, Bendixen, Muus, and Schei (1994) examined rationale for solicitation of medical advice. Compared to women without a CSA history, a greater percentage of CSA survivors sought consultation specifically for an eating disorder.

Thus, CSA survivors have been shown to be negatively impacted in many areas of daily functioning subsumed within the spheres of eating, sleeping, and sexual relations. Additionally, associations have been shown between CSA and later engagement in self-harm behaviors such as substance abuse and suicidality. Evidence also indicates that survivors manifest difficulties in their interactions with others.

Interpersonal Challenges or Distinctions

Within the interpersonal realm, CSA survivors have been shown to present with specific challenges. Research has supported difficulties in relationships and the trusting
others, general fear of men, and changes in sexual orientation consequent to CSA. Given both the tendency for males to be in the perpetrator role and the underlying corruption of trust inherent in CSA, these outcomes would be anticipated or, in the least, understandable. Nevertheless, while adaptive in certain respects, some of these interpersonal tendencies serve to contribute to greater problems for the CSA survivor. Difficulties in relationships and trusting others may result in increased loneliness, anxiety, and suspicion. A general fear of men may heighten vigilant and avoidant tendencies, while it may also exacerbate feelings of powerlessness and diminished control over one’s own person. Finally, while prejudice is a possibility, homosexual experiences in and of themselves are not considered problematic; however, confusion regarding one’s sexual orientation may increase anxiety until resolution and acceptance have been achieved. We turn now to a discussion of specific research supporting these conclusions.

Hulme and Grove (1994) have identified both an inability to trust others and the experience of relationship difficulty as highly frequent among their sample of CSA survivors. The former symptom was additionally supported in Romans, Martin, Anderson, O’Shea, and Mullen’s (1995) sample. These authors also report survivors manifesting a general fear of men, a finding that was also reported by Bendixen, Muus, and Schei (1994) using a student sample. Bagley and Ramsey (1986) found a higher divorce rate and lower quality ratings of current marriage among their community CSA sample.

Lastly, there has been evidence of an increased incidence of homosexual experiences among CSA survivors (Runtz & Briere, 1986; Meiselman, 1978).
significantly higher incidence of homosexual contact was reported by Runtz and Briere (1986) when comparing sexually abused females to a control group. Specifically examining female incest survivors, Meiselman (1978) found a "significant minority" (30%) actively sought lesbian relationships. The author indicates the participants reported having no such proclivities prior to the incest experience. However, she also qualifies this finding as follows: "While father-daughter incest frequently results in a lesbian orientation in women who are psychologically disturbed, incestuous experience is not a background factor for the great majority of self-identified lesbians" (p. 260). Of interest, no longitudinal data has been found regarding either the continuity or temporality of lesbian behavior in direct response to traumatic sexual experience.

Circumstantial Proclivities

Finally, a limited number of studies have found greater frequency of certain negative circumstances among CSA survivors. For instance, in their prospective study, Fergusson, Horwood, and Lynskey (1997) found a greater propensity for sexual revictimization among those females experiencing CSA. In fact, these authors found the likelihood of revictimization to increase commensurate with the severity of reported CSA. Using a college sample Stevenson and Gajarsky (1991) found a high concordance between those women reporting an unwanted childhood sexual experience with an adult and those reporting an unwanted sexual experience in adulthood.

Another revictimizing circumstance of CSA survivors is domestic violence. Briere (1984) found almost half of his sexually abused sample had been victims of violence in an adult relationship. This incidence was almost three times greater than that of the
control group. Goodwin, Cheeves, and Connell (1990) report 55% of their incest survivor group indicated having been battered by a sexual partner.

Domestic violence certainly represents a substantial problem for CSA survivors. As has been delineated, however, this is just one of many challenges experienced. Numerous sequelae have been identified subsequent to childhood sexual victimization. While the glut of such manifestations fall within the psychological domain, adult CSA survivors are also significantly impacted behaviorally, physiologically, socially, and circumstantially.

**Adolescent and Adult Sexual Victimization**

Adolescent and adult sexual victimization can be described as including the scope of behaviors spanning from rape to unwanted sexual contact. A substantial range of activity is subsumed within this description and further clarification is in order. Rape may be defined as vaginal or anal intercourse (penetration is sufficient), cunnilingus, or fellatio occurring under either of the following conditions: (1) the offender compels the other person via force or threat of force or (2) the offender utilizes drugs or other intoxicants to substantially impair the other person’s control or judgement as a means of preventing resistance (Koss, Gidycz, & Wisneiwski, 1987).

Slightly lesser in degree than rape, sexual coercion involves sexual “intercourse subsequent to the use of menacing verbal pressure or the misuse of authority” (Koss, Gidycz, & Wisniewski, 1987, p. 166). Lesser still is the act of unwanted sexual contact. This type of victimization includes sexual behavior that does not involve attempted penetration (e.g., kissing, fondling); however, does involve the use of coercive measures...
such as verbal pressure, the misuse of authority, threat of harm, or the use of physical force. It should also be noted that attempted rape, or a thwarted attempt at any of the above listed behaviors, falls under the purview of sexual victimization as well.

Whether one looks specifically at rape or more broadly at sexual victimization, the extent of this problem in our society is vast. In their hallmark national study of sexual victimization on college campuses, Koss, Gidycz, and Wisniewski (1987) found rates of sexual victimization among college women to be approximately three times greater than rates reported in the general population. These investigators found that 15.4% of their sample reported having had an experience meeting the criteria of rape, another 12.1% reported experiencing attempted rape. Coercion and sexual contact were reported by 11.9% and 14.4% of their sample, respectively. In all, more than half of the women surveyed had experienced some form of sexual victimization since the age of 14.

Other studies examining prevalence within a college population include Aizenman and Kelley (1988) and Mynatt and Allgeier (1990). Aizenman and Kelley found 22% of their female sample reported that they had been involved in a situation they would call acquaintance rape. Fifty-one percent of the participants reported having successfully avoided an attempted acquaintance rape, 29% reported having been forced to have intercourse against their will, and 43% reported experiencing forced sexual contact. Mynatt and Allgeier found 26% of their female sample reported experiencing a coercive incident involving completed intercourse and 16% reported experiencing a coercive incident involving attempted intercourse. Ninety-two percent of these women knew their assailants and just 6% of these incidents were reported to the authorities.
Using random, nation-wide community sampling methodology, Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) found lifetime prevalence of rape among U.S. women to be 12.65%. The rate of other sexual assault was reported as 14.32%. These investigators utilized the criteria of force or threat of harm and did not include acts of coercion within their definition; hence, prevalence of sexual victimization would likely be greater including coercive acts.

Roth, Wayland, and Woolsey (1990) also examined prevalence of sexual victimization. These researchers asked female university students and university employees whether they had ever had “sexual intercourse, attempted sexual intercourse, or other explicit sexual acts with a man in a situation involving force or threat of force” (p. 172). Using this framework, 13% reported a lifetime history of sexual assault; of these, two-thirds told another person and 18% reported the incident to the police.

As alluded with the Mynatt and Allgeier (1990) and Roth, Wayland, and Woolsey (1990) investigations, however, the reporting of sexual assault is not commensurate with its incidence. Koss (1985) found 38% of college women interviewed reported experiences which met the legal definition of rape or attempted rape; only 4%, however, reported these incidents to the police.

Focusing on factors affecting differences in acknowledgment amongst women for having been a rape victim, Koss (1985) failed to distinguish any personality or attitudinal variable discriminating acknowledged from unacknowledged rape victims. She did, however, find that unacknowledged rape victims were significantly more highly acquainted with their offender than acknowledged victims. Additionally, unacknowledged
victims more likely had victimization experiences involving less verbal pressure and physical force.

Although acknowledgment is not the only factor impacting a woman’s likelihood of reporting sexual assault, it is a necessary precursor. If victims are less likely to acknowledge and, subsequently, report sexual assault if they know their assailant, the results reported by Gidycz, Coble, Latham, and Layman (1993) and Mynatt and Allgeier (1990) further explicate the extreme underreporting of this crime: Both of these investigations found that 92% of their victim sample had been assaulted by someone known to them. Other factors associated with acknowledgment of assault as rape include increased forcefulness of the assault itself, greater resistance, and clearer refusal on the part of the victim (Layman, Gidycz, & Lynn, 1996).

Even when acknowledged, nevertheless, there are many reasons for the extreme underreporting of sexual assault; shame, responsibility, stigmatization, and misperception are all possible factors. Shame and a sense of personal responsibility can inhibit a woman’s likelihood of report. Oftentimes, women express responsibility for having put themselves into a situation resulting in sexual assault. Culturally, this has been perpetuated by the myth that a woman deserves to be raped for her manner of dress or “mixed messages” conveyed. The fear of stigmatization as tarnished or “used goods” may also serve to prevent reporting; although evidence for this outcome has not been found in the empirical literature, it has been supported in the media and may deter reporting.

There were 95,770 rapes reported to United States police departments during the year 1996 (Bureau of Justice Statistics, 1999), translating to a reported crime rate of .07%
in the female population. As elucidated, sexual assault is a highly underreported crime. While impossible to definitively tabulate, it would not be contested that actual incidence of sexual assault numbers well over several hundred thousand each year. Although hindered in our assessment of the true scope of this offense, sexual victimization is clearly a paramount problem facing women in our society today and research has shown numerous outcomes associated with this experience.

Effects of Adult Sexual Victimization

While fewer in number, and perhaps shorter in duration, than sequelae associated with CSA, the effects of adult sexual victimization should not be discounted. The psychological consequences of a sexual assault experience for the victim still generally outlast any bodily damage which may be inflicted during the experience. As explicated in Table 2, virtually all aspects of the person’s daily life can become compromised in the aftermath of a sexual victimization experience: work, sleep, sex, social functioning, and general mental health.

Insert Table 2

Post-traumatic stress disorder. A frequently cited outcome of rape is post-traumatic stress disorder (PTSD). Utilizing a prospective design, Rothbaum, Foa, Riggs, Murdock, and Walsh (1992) found 94% of their sample of female rape victims met symptomatic criteria for PTSD two weeks after assault. Although symptoms abated for some women, 47% continued to meet diagnostic criteria 3 months after the victimization.
experience. Resnick, Kilpatrick, Dansky, Saunders, and Best (1993) found lifetime prevalence of PTSD for those reporting a rape experience to be 32%, while lifetime prevalence for those reporting sexual assault other than rape (i.e., molestation or attempted sexual assault) was 30.8%. Although recency of assault was not provided, the authors report current PTSD in their sample of rape and other sexual assault victims to be 12.4% and 13.0%, respectively.

**Fear and anxiety.** While full-blown PTSD is a frequent response to rape, other responses have been noted to occur as well. Specifically, intense rape-related fear and general diffuse anxiety are fairly common. Such symptomatology appears to be the norm and has been reported as much as 16 years after the assault experience (Calhoun, Atkeson, & Resick, 1982). Veronen and Kilpatrick (1980) found just 23% of rape victims to be asymptomatic for fear one year after the sexual assault. Further, in a longitudinal study comparing rape victims and matched nonvictims, Kilpatrick, Resick, and Veronen (1981) found the victim group to be significantly more anxious, suspicious, fearful, and confused one year after the rape experience.

**Depression.** Another symptom noted in the literature is depression. This outcome has been reported to be highly frequent among rape survivors, especially directly after the assault experience. Frank and Stewart (1984) report 43% of a sample of recent rape victims met diagnostic criteria for major depression. In examining long-term reactions to rape, Ellis, Atkeson and Calhoun (1981) found victims were more depressed, reported less enjoyment from activities, and experienced more problems with family members than a group of nonvictim controls. Nevertheless, this same team of investigators (Atkeson,
Calhoun, Resick, & Ellis, 1982) also report that depression may attenuate more readily than fear/anxiety. In one report they found no statistical differences in depression between victims and nonvictims as little as four months post assault.

**Anger.** Anger is another response found among survivors of sexual assault and other crimes (Hyer, O'Leary, Saucer, Blount, Harrison, & Boudewyns, 1986). This reaction was found more frequently among those against whom a weapon had been used (Riggs, Dancu, Gershuny, Greenberg, & Foa, 1992). Rationale for this distinction includes the exacerbation of anger naturally occurring in circumstances of personal violation. Not only has the victim been violated once via the sexual assault, but again through the threat or assault with a weapon. Hence, the victim is doubly violated and may experience a greater likelihood of resultant anger than if a single personal violation had occurred.

**Impaired social functioning.** Also cited in the literature are difficulties in social functioning directly subsequent to rape (Nadelson, Notman, Zackson, & Gornick, 1982; Resick, Calhoun, Atkeson, & Ellis, 1981). There is, however, equivocal evidence in the literature as to how long such difficulties persist. Resick, Calhoun, Atkeson, and Ellis (1981) found significant differences between victims and nonvictims in level and type of interaction with friends, social discomfort, loneliness, and outside interests for two months following the assault. After this time, no significant differences were noted.

In comparison, Nadelson, Notman, Zackson, and Gornick report a follow-up of rape victims 12 to 30 months after assault. These investigators found 76% of their sample reported suspiciousness of others, 61% felt restricted in going out, 51% reported sexual
difficulties, 24% reported sleep disturbance, and 24% reported impaired concentration, all of which would reasonably impact on social functioning. Thus, while the Resick et al. Study suggests that impairment in social functioning abates relatively soon after assault, the Nadelson et al. Study suggests such difficulties persist up to 2½ years post assault. One significant difference between these studies involves the behaviors being assessed. Resick et al. used highly behavioral descriptors to address social functioning while Nadelson et al. used self-report focusing more on internal states. Hence, the Resick et al. participants might rank themselves highly on some of the dimensions assessed by Nadelson et al. while still evidencing improvement in objective measures of social interactions and outside interests.

Sexual difficulties. As alluded to above, sexual problems following rape are quite common. Fear of sex and decreased arousal/desire were the most frequent dysfunctions reported in Becker, Skinner, Abel, and Treacy’s 1982 sample. Another study indicates that one-third of victims reported decreased sexual satisfaction up to several years following the assault (Norris & Feldman-Summers, 1981), while 51% of the Nadelson et al. (1982) sample reported experiencing sexual difficulties at follow-up.

Psychosomatic complaints. Victims of sexual assault may also experience a number of difficulties related to bodily integrity and regulation of affect and bodily rhythms. Norris & Feldman-Summers (1981) found a significant increase in the percentage of rape victims reporting psychosomatic difficulties after the assault compared to reports of the same symptomatology existing preassault. Such difficulties include: sleep problems, depression, frequent crying, appetite or eating problems, rapid changes in
mood, loss of temper, excitability, headaches, cystitis, and menstrual irregularity. Also
negatively impacted was the woman’s likelihood of going out alone to movies/concerts or
bars.

In summary, PTSD symptomatology, fear/anxiety, depression, anger, and
impaired social and sexual functioning have been some of the sequelae reported in
response to adult sexual victimization. While there is some disparity in the duration of
such symptoms, they present significant impairment in general functioning nevertheless.
This is clearly a major social and mental health issue impacting women today, in
particular, at highest risk, those women with a history of CSA.

Sexual Revictimization

Sexual revictimization denotes the occurrence of more than one sexually
victimizing experience in an individual’s life. The term has been applied to victims who
experience more than one sexual assault experience within the same developmental stage.
However, it is generally not used in those instances wherein the assaults are perpetrated
by the same individual (e.g., when a child is repeatedly sexually abused by her step-father
between the ages of 8 and 12). Revictimization is most often used when discussing sexual
victimization occurring in two different life stages. Specific to this investigation, sexual
revictimization is defined as the experience of both childhood sexual abuse or adolescent
sexual victimization and later sexual victimization as an adult.

A history of CSA places a woman at increased risk for further assault (Fergusson,
Horwood, & Lynskey, 1997; Stevenson & Gajarsky, 1991); indeed, Wyatt, Guthrie, and
Notgrass (1992) found CSA survivors to be 2.4 times more likely to be sexually

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victimized in adulthood compared to women without a history of CSA. In a review of the literature, Messman and Long (1996) note that estimated rates of revictimization range from 16 to 72%. Given Bagley and Ramsay’s (1986) community-based estimate indicating that 22% of females experience ‘serious, unwanted childhood sexual assault’, it can then be extrapolated that anywhere from 3.5 to 15.8% of all women will experience sexual revictimization in their lives.

Clearly, revictimization occurs in epidemic proportions and, as such, major efforts should be put forth to eradicate it. First, however, it is necessary to gain a greater understanding of this problem. Accordingly, research is currently focused in three broad areas: investigation of theoretical explanations for revictimization, determination of individual characteristics predictive of revictimization, and identification of mechanisms which might assist in reducing incidence of revictimization. We will begin with the theoretical explanations which have been posited before proceeding to a discussion of available empirical findings.

Explanations for Sexual Revictimization

Various theories have attempted to explain why CSA survivors are at greater risk for victimization in adulthood than non-victimized women. Although none have been empirically validated to date, supportive evidence can be found in some instances and will be discussed in turn. It should also be kept in mind that, although presented as distinct, these theories are not mutually exclusive and considerable overlap exists between them.
Social learning theory. One of the more comprehensive attempts at explaining revictimization has involved the application of social learning theory. Applying learning theory, it is suggested that the initial sexual abuse results in learned maladaptive beliefs, attitudes, and behaviors, commensurate with the victim's failure to learn adaptive behaviors (Wheeler & Berliner, 1988). The victim may acquire a repertoire of inappropriate sexualized behaviors through the use of modeling, reinforcement, and punishment by the perpetrator.

A child involved in an incestuous relationship with her father, for instance, might acquire a sexual repertoire through observational learning of the non-perpetrating parent's behaviors (e.g., greeting her spouse with a passionate kiss). Sexual activity may also be directly modeled by the perpetrating parent as a means of teaching the child what is pleasurable to the perpetrator. Such behavior could be reinforced by the parent in one of two ways: either through provision of praise, privileges, and/or attention, or negatively through the removal of an aversive stimulus (i.e., the parent ceases the sexual interaction once his needs are satisfied). Finally, punishment may also occur, especially if the child does not indulge the abusive parent's inclinations. Once these behaviors are learned by the CSA victim, they may be used with other individuals and in other situations, marking the emergence of a generalized pattern of sexualized behavior.

This perspective also posits that sexual abuse may serve to reduce the child's sense of self-efficacy. This occurs as a result of the perpetrator's disregard for the child's wishes and the child's inability to modulate her sense of self through control of her own person. Thus, the child learns that she is ineffective in influencing her experiences and
self-efficacy is lowered. According to social learning theory, both the sexualized behavioral repertoire and the decreased sense of self-efficacy serve to contribute to a predisposition for victimization in later life. The CSA survivor inadvertently communicates sexual responsivity via inappropriate sexualized behaviors. At the same time, her diminished sense of self-efficacy serves to reduce the likelihood of her asserting her own preferences or fighting off a sexual advance/attack.

Sex role stereotyping. Walker and Browne (1985) have utilized sex role stereotyping in their explanation for revictimization. According to this theory, girls that are raised in traditional/sexist environments have been taught that a female’s role is one of passivity, subservience, and dependence. Females’ needs are subjugated to those of males, while any behavior contrary to these viewpoints may be met with punishment. Within this environment, emotional, physical, and sexual abuse can be viewed as acceptable and even expected, merely another encumbrance of being female.

Additionally, girls in this environment are taught that personal relationships are the primary source for their self-esteem. Thus a female raised in a strictly traditional environment such as this will come to believe that her self-worth is solely dependent upon maintaining a personal relationship within which she is an insignificant factor, entirely dependent and passive in her own existence. As such, the woman’s experience in a relationship will be completely dependent on the inclinations of her partner while being unquestionably accepted and expected by her. These factors then serve to make her vulnerable to revictimization in adulthood.
Psycho-environmental vulnerability. This explanation for revictimization (Ellis, Atkeson, and Calhoun, 1982) posits that the compromised level of psychological adjustment resulting from CSA not only makes a woman more vulnerable but also negatively affects her vocational success. This leads to a lower income level, which then necessitates the survivor living in a higher crime neighborhood. According to this theory, the survivor is then “singled out for attack because [she is] usually alone, perhaps identifiable as vulnerable, and less likely to be taken seriously by the police” (p. 224).

This theory lends itself more to stranger- than acquaintance-rape because the incidence of acquaintance rape has not been found to be associated with higher or lower crime neighborhoods. Given this caveat, it does have some support. CSA survivors do frequently evidence compromised psychological adjustment which could negatively affect the vocational arena (e.g., low self-esteem, depression, confusion, learning problems). Additionally, drug and alcohol abuse, dissociation, and depression may all serve to make a woman more vulnerable to assault through diminished vigilance and self-efficacy. Therefore, the exposure to greater crime risk by way of living in a higher crime neighborhood, decreased vigilance and a “victim posture” while being alone could all serve to increase the likelihood of further victimization. Nonetheless, acquaintance rape has been found to be such a preponderance of sexual assaults (84% according to Koss, Gidycz, and Wisniewski’s 1987 national sample) that this theory is highly limiting and almost meaningless as a result.

Object relations. Carey (1997) supports an object relations explanation for revictimization. Within this theory, the need for a secure parental attachment is
paramount for child development. When a child recognizes parental behaviors that are antithetical to the development of a secure attachment, such as being sexually abusive, "they immediately deny and distort reality so as to believe that parents are still safe when in fact they are not...a 'split' occurs and these children place the 'bad' onto themselves 'to keep parents safe'" (Hyams, 1994 cited in Carey, p.358). This serves to maintain the child's view of her parent as still being inherently good and safe while placing the problem upon herself. Maladaptive cognitive and behavioral patterns develop as a result, in addition to depression, learned helplessness, and a sense of inadequacy. As Carey states:

The often traumatic, promiscuous behavior of sexual abuse survivors that feeds the revictimization cycle appears logical once the secondary gain becomes clear. That is, the secondary gain of reinforcing that self rather than parents is the problem (to protect parental attachment) is more important than avoiding further trauma. (p.358)

Such commitment to maintaining this negative self-view as a means to continue protecting their parental images and attachment continues into adulthood and is viewed as a strong contributor to the revictimization process. This theory, however, is limited to instances of incestuous abuse involving the parent. Here again, no empirical testing has been carried out.

Negative identity formation. Price (1993) focuses on the issue of self-hatred and a distinct identity formation which may occur within incest survivors. Given the sexually abusive home environment, the child learns that safety takes precedence over authenticity
of self. In this process, different aspects of the self are either idealized or devalued and despised. Projection, projective identification, denial, and compartmentalization are used to “disown” the unwanted aspects of the self. Such adaptations, which were initially crucial for survival, eventually become intertwined in the victim’s perception and definition of herself. Hence, the child becomes more and more alienated from her true self. Any emergence of the despised aspects will result in anxiety, conflict, and self-hate, thereby perpetuating the negative, inauthentic identity formation via the utilization of further defense strategies.

While striving to master the trauma of the original incest experience, survivors have a tendency to seek out life situations that resemble their earlier experiences. Such situations include prostitution, domestic abuse, marital discord, as well as sexual revictimization. Their lack of ego strength and necessary skills, however, result in a failure to master the trauma. In accord with this theory, a further deterioration of self-esteem occurs and the revictimization cycle continues.

Impaired risk recognition. Lastly, several researchers have begun to focus on impaired risk recognition as a factor explaining the revictimization process. Impaired risk recognition means that the person is not as skilled at identifying signs that indicate risk for sexual victimization. From this perspective, the victim’s previous history of abuse leads her to accept and expect abusive treatment (e.g., sexual coercion, a lack of control or say over her own body, etc.). Once such treatment is expected as the norm, it is no longer able to serve as a warning signal for impending danger. Whereas nonvictimized women may identify early warning signs for possible victimization (e.g., attempts at
seclusion or intoxication, subtle coercion) and be able to effectively protect themselves from a sexually abusive incident, women with a history of prior victimization may view these early warning signals as the norm and, consequently, make no attempt to control the situation until victimization becomes imminent.

Investigation of this theory was conducted by Wilson, Calhoun, and Bernat (1999). They assessed risk recognition using audiotaped vignettes of a date rape situation. The audiotape vignette of a heterosexual couple on a date involved increasing levels of coercion/force. Participants were asked to listen to the tape and identify when the man had "gone too far." Response latency was the measure of risk recognition. These researchers found women with a history of revictimization demonstrated poorer risk recognition than either women with a single assault experience or those reporting no such history. Women with a single assault experience did not differ on risk recognition from those with no such history. Only this latter result would have served as support of the impaired risk recognition theory for (initial) revictimization.

Meadows, Jaycox, Orsillo, and Foa (1997, cited in Meadows, Unisky, & Jaycox, 1998) also investigated this theory of revictimization. Using verbally presented scenarios with increasing levels of coercion, these investigators assessed risk recognition by asking participants to indicate the point, if any, at which they would begin to feel uncomfortable. Women who identified points further into the vignette were determined to have lower risk recognition. No differences were found between women with a sexual assault history and those without.

Somewhat related to this theory however, they did find that CSA survivors
indicated a significantly later point at which they would take some action to change the situation or leave. These results suggest that it may not be risk recognition per se that differentiates women who will be revictimized. Instead, it may actually be an unwillingness or inability to take action in a timely fashion which places CSA survivors at greater risk for revictimization. This finding suggests that the CSA survivor will not attempt to extricate herself or protest while distinguishing a situation as presenting greater risk. Instead, she may remain in a situation until sexual assault becomes imminent, at which point her defense attempts are most likely to be benign.

**Empirical Studies on Revictimization**

Although a relatively new field of investigation, a growing number of studies have been carried out in the area of sexual revictimization. These investigations have served to provide some initial impressions regarding factors that put CSA survivors at risk for revictimization.

**Cross-sectional research.** The majority of investigations have been cross-sectional in nature, primarily identifying differences between women with a history of sexual revictimization compared to those with either a history of a single incident of sexual victimization or no such reported history.

In one of the more comparative studies to date, Cloitre, Scarvalone, and Difede (1997) compared women with a sexual revictimization history, women sexually assaulted only in adulthood, and those without a history of sexual assault. Both victimized groups evidenced high rates of PTSD and depression. Compared to the no abuse group, the revictimized group also evidenced greater levels of dysthymia, generalized anxiety...
disorder, and simple and social phobias. When compared to the single assault and no assault groups, the revictimization group experienced significantly greater incidence of alexithymia, higher risk for dissociative disorders, and more suicide attempts.

The revictimized women were also the only group to experience clinically significant interpersonal problems as measured by the Inventory of Interpersonal Problems. This group scored significantly worse than the other groups on all of the six subscales: assertive, sociable, submissive, intimacy, responsible, and control. The sexually revictimized women had difficulties being assertive and sociable, they felt overly responsible, were more submissive, evidenced greater difficulties with intimacy, and had a greater tendency to see themselves as overly controlling. A lack of assertiveness and tendency toward submissiveness could both directly contribute to risk of revictimization. Sociability and intimacy problems might lead to increased loneliness, a construct posited in the current study to heighten risk. Likewise, the guilt associated with hyper-responsibility and a tendency to view oneself as overly controlling may result in the adoption of compensatory measures. The person may relinquish both control and her sense of responsibility in a high-risk situation; both factors which would serve to increase her likelihood of further victimization.

In another comparative study, using participants from a rape crisis center, Ellis, Atkeson, and Calhoun (1982) compared women with a single-incident history to those reporting multiple rapes in adolescence/adulthood. These investigators found the more victimized group to be poorer and to lead more transient lifestyles than single-incident victims. This group also reported a history of more frequent non-rape victimization such
as physical abuse and violent crime. Other differences found between the groups involve:

social network, sexual adjustment, paranoia/anger/hostility, depression/suicidal behavior,
and psychiatric treatment history. In all cases, the multiple-victimization group fared
poorer than the single-victimization group.

Norris, Nurius, and Dimeff (1996) examined differences between sexually
victimized and nonvictimized sorority women in both predicting the likelihood of sexual
assault as well as how they would respond in such a situation. The investigators
hypothesized that psychological factors such as concern over embarrassment, fear of
rejection, and the disabling effects of alcohol would adversely affect a woman’s
likelihood of using more assertive measures in response to the threat of sexual aggression
by an acquaintance. They also hypothesized that greater psychological barriers would be
found in the prior victimization group.

Indeed, they did find significant differences between women who had experienced
minimally one form of sexual aggression by an acquaintance within the previous year and
those who had not. Women who had experienced a sexually aggressive incident had
higher estimates of encountering future sexual aggression; they also reported a higher
likelihood of using indirect methods of resistance and a lower likelihood of using more
direct methods such as verbal assertiveness or physical resistance. This group reported a
higher likelihood that embarrassment, fear of being rejected, and the effects of alcohol
consumption would pose barriers to their effectively removing themselves from a
threatening situation. They also reported higher peak blood alcohol levels and a greater
number of recent sexual partners.
These results suggest that prior victimization adversely impacts a woman’s willingness or ability to protect herself from sexual assault. Using less direct methods of resistance, having a fear of embarrassment which hinders taking action, and increased alcohol levels all serve to place a woman at greater personal risk. Especially within closely affiliative groups, the fear of peer disapproval may be a particularly salient mechanism impacting a woman’s attempts at self-protection. Instead of implementing more assertive and effective means to cease the assault (i.e., screaming, hitting or striking out), results indicate that women with a history of victimization are more likely to employ less effective strategies (e.g., joking that the perpetrator is coming on too strong). Taken together, the behaviors and motivations most endorsed by the previously victimized group lend support for their heightened risk of further victimization.

As discussed above, Wilson, Calhoun, and Bernat (1998) examined the role of risk recognition in sexual revictimization. Using audiotaped vignettes, they assessed the differential impact of various levels of victimization on judgements of when a man’s sexual advances have advanced to the point of placing the woman at risk for sexual assault. Participants were asked to press a button at the point in which the woman in the vignette became in danger of sexual assault. Response latency was then utilized as an indicator for risk recognition. Results suggest that women with a history of revictimization demonstrate poorer risk recognition than either women with a single assault experience or those reporting no such history.

These investigators also examined the difference between revictimized women who were PTSD positive and those who reported no such symptomatology. While the
PTSD negative group took significantly longer to indicate that the woman in the vignette was in danger of being sexually assaulted, the PTSD positive group had response latencies more closely approximating the nonvictimized group. This latter finding supports the proposition that PTSD-related arousal serves as a buffering agent by increasing sensitivity to environmental cues which forecast a sexually coercive interaction.

As of this time, cross-sectional investigations have found revictimized women to have greater incidence of alexithymia, dissociative disorders, suicide attempts, and other interpersonal or psychological difficulties. Such women are also generally poorer and more transient. Additionally, they have been shown to have greater reluctance toward direct thwarting of sexual advances and to recognize a progressively dangerous sexual situation as having gone “too far” later than women without such history.

One of the difficulties associated with cross-sectional designs, however, is the inability to determine the sequence of variables. For instance, do alexithymia, dissociation, and increased alcohol consumption lead to revictimization, or does revictimization lead to alexithymia, dissociation, and alcohol consumption? Only a prospective design can address this issue.

Prospective designs. Few prospective designs have been employed in investigating sexual revictimization. However, in one such case the impetus has focused on informing predictive characteristics. In their landmark study, Gidycz, Hanson, and Layman (1995) examined the occurrence of sexual victimization in a sample of college women. These researchers first assessed for childhood and adolescent sexual
victimization and then followed up prospectively at 3, 6, and 9 months. In addition to rates of victimization/revictimization, the authors examined possible mediators such as family adjustment, alcohol use, psychological adjustment, interpersonal functioning, and number of sexual partners.

Results indicate that 61% of the sample had experienced sexual revictimization; 25% had been victimized only once either in childhood, adolescence, or adulthood. Just 14% of the 178 women completing the survey had no history of sexual victimization and did not experience any victimization during the course of the 9 month study. Further, the authors found that victimization status at each time period was dependent upon status during the previous time period and increasing levels of severity resulted in increasing chances of subsequently being victimized. Once a subject had been victimized, it was more likely that she would also stay within the same level of severity of victimization during successive time periods. Also of import, these authors did not find any mediating variables examined to have significant impact within this process.

In another prospective study, Hanson and Gidycz (1993) examined sexual assault prevention programs. As is common in most prevention approaches, the program investigated by Hanson and Gidycz included a rape myths debunking session, videos depicting both an acquaintance rape scenario and protective behavior modeling, an informational component, and group discussion. Specific objectives of the program were to increase participants’ awareness of the pervasiveness of sexual assault, dispel common myths regarding sexual assault, educate participants concerning social forces that foster a rape-supportive environment, and educate participants regarding practical strategies for
preventing rape. Specific behaviors targeted for change in program participants included dating behaviors associated with acquaintance rape, sexual communication, and the reduction of sexual assaults occurring over the 9-week period of investigation. Results indicated that, while the program was found to be effective in reducing the incidence of sexual assault in women without a history of sexual victimization, it was not found effective for women with such a history. Given that this group is at a significantly higher risk, an effective means of intervening is of utmost importance. Greater understanding of the factors underlying this increased risk must be acquired in order to inform prevention programs.

Purpose

This study was undertaken to add to the literature regarding characteristics that may predispose a woman to greater risk of sexual revictimization. While many characteristics have been associated with CSA and adolescent sexual victimization, which of these characteristics specifically lead to an increased risk for revictimization has, as yet, not been determined. Additionally, although differences have been noted between women who have experienced sexual revictimization and those who have not, whether these differences are actual predictors for revictimization remains speculative. It is crucial to understand whether these differences between once-victimized and multiply victimized women reflect effects of revictimization or risk factors for revictimization. Such information would greatly facilitate the conception of prevention efforts in the future. The identification of differences that occur prior to revictimization would both enable greater identification for those highest at risk and direct our attention toward specific areas of
remediation. By allowing for examination of differences that may be in existence prior to revictimization and determining whether such differences identify those women with a CSA history who will go on to experience revictimization, this study sought to address these issues using a prospective design.

Hypothesis

This study examined the hypothesis that dissociative symptomatology, alexithymia, alcohol use, and loneliness are risk factors predicting revictimization of CSA survivors. Each of these variables is associated with particular characteristics which can be attributed with an increased risk for sexual victimization.

The dissociation of environmental perceptions and consciousness can hinder recognition of cues which would otherwise signal possible risk. A woman with increased dissociative symptomatology may not associate situations known to increase vulnerability (e.g., being alone with someone, increasing alcohol consumption) with the increased likelihood of assault. Additionally, she may not identify the coercive behavior of another with increased risk to herself. Her lack of integration of consciousness, environmental perception, memory, and identity serve to decrease the likelihood of heightened risk perception. Thus there can be greater exposure to high-risk situations and greater sexual victimization as a result. This has been supported by Brick (1999) and Cloitre, Scarvalone, and Difede (1997) who found higher levels of dissociation in revictimized women.

Somewhat related, alexithymia, or the difficulty in recognizing and verbalizing feelings, impairs a woman’s ability to “fully experience and recognize internally
generated ‘danger’ signals when confronted with threats to self such as unsafe environments or potentially dangerous individuals” (Cloitre, Scarvalone, & Difede, 1997, p. 449). In this sense, while dissociative symptomatology impairs a woman’s recognition of risky situations, alexithymia hinders her emotional interpretation of them.

Another process by which alexithymia can contribute to increase risk is through the other person’s interpretation of the communication of the CSA survivor. Alexithymia can be presented both through a generally flattened affect and through a diminished ability to express an emotional state in accord verbally and through facial expression. Both of these characteristics can lead others to minimize, or completely disregard any protestations to their sexual advances. As a result, the advances continue and revictimization occurs.

Increased alcohol use is also posited to predict sexual revictimization. Alcohol abuse has been associated with a history of CSA (Hulme & Grove, 1994, Sedney & Brooks, 1984, Peters, 1988, Stein, Golding, Siegel, Burnam, & Sorenson, 1988). It has also been linked with adult sexual victimization (Synovitz & Byrne, 1998) and sexual revictimization (Brick, 1999). The depressive effect of alcohol serves to suppress inhibitions, impair cognitive functioning, and adversely impact motor responses, all factors that may place a woman at greater risk of sexual assault.

Suppressed inhibitions may lead a woman to engage in sexual behaviors such as kissing and petting more readily. It may also lead her to engage in behavior which is more sexually provocative in nature. In both cases, such actions serve to increase risk of sexual advances, coercion, or assault.
Impaired cognitive and motor functioning impacts risk recognition through the woman’s diminished capacity to clearly identify or effectively responding to sexually coercive attempts. She may not interpret propositions for sexual activity as they are intended and may more easily be physically manipulated into such behavior. A weakened motoric state then makes it less likely that she will be able to fend off sexual advances.

And finally, although loneliness has not been examined with respect to revictimization, it is theorized here to have a significant role. There are two posited means through which it might serve to increase risk: indirectly, as a mediator of psychological adjustment in CSA survivors and directly, by increasing need or desperation for affiliation, attention, and interaction.

Tsai, Feldman-Summers, and Edgar (1979) found the presence of supportive others positively mediates the psychological adjustment of CSA survivors. From this, one must extrapolate both directions to link loneliness and revictimization. First, the presence of supportive others must be negatively associated with loneliness: lonely individuals are not likely to have supportive others in their lives. Second, psychological maladjustment must lead to greater victimization. In the only prospective investigation of this to date, Gidycz, Hanson, and Layman (1995) did not find evidence of psychological adjustment mediating sexual revictimization. Nonetheless, Cloitre, Scarvalone, and Difede (1997) did find greater incidence of PTSD and depression among sexually victimized women and greater incidence of PTSD, depression, alexithymia, dissociation, and suicidal behaviors among sexually revictimized women. These results may suggest the possibility that specific aspects of psychological adjustment contribute to risk rather than the whole.
construct overall.

More directly, loneliness may increase risk of sexual revictimization through compensatory behaviors engaged in by the survivor. CSA survivors may feel increased loneliness by virtue of having past experiences which they believe are not easily shared or empathized by others. The heightened loneliness they experience fuels the drive for affiliation and affection; a desperation for interpersonal connection may be felt. In this state, a woman is less likely to chance losing the attention and interpersonal connection of another person by resisting any sexual advances made. Some support for this has been reported by Norris, Nurius, and Dimeff (1996). They found women with a history of victimization less likely to use direct methods of resistance for fear of being rejected. These investigators, however, did not specifically measure loneliness of their participants.

All of these factors, dissociation, alexithymia, alcohol, and loneliness are posited to contribute to sexual revictimization. Each has been linked with CSA and rationalized for its contribution to revictimization. Using a prospective design, this investigation sought to establish support for their predictive role.

Method

Participants

Participants were 350 female undergraduate students recruited from the introductory psychology course at the University of Montana. All participants received credit for their participation as partial fulfillment of the course’s research requirement. As the focus of this study involves risk of sexual victimization, those participants over the age of 30 were screened out because of low risk status. Twelve participants met this
criteria and were subsequently removed from any analysis. The remaining 338 participants were assigned to groups based on reported history of childhood sexual victimization. For the purposes of this study, childhood victimization was defined as sexual touch obtained through threat or force, or sexual touch by someone five or more years older regardless of means obtained, before the victim was 18 years old.

Information from participants was also obtained regarding non-contact abuse experiences prior to the age of 14 (e.g., exposure). Although these experiences can be traumatic, they are quite common and likely not as traumatic, in general, as abuse involving physical contact. Since the original intention of this study was to examine possible mechanisms contributing to heightened risk of sexual victimization among CSA survivors, a clear-cut distinction between CSA survivors and non-CSA survivors was sought. Although non-contact abuse survivors have been included in other studies of sexual victimization (Gidycz, Hanson, & Layman, 1995; Gidycz, Coble, Latham, & Layman, 1993; Wyatt, Guthrie, & Notgrass, 1992), the CSA definition utilized in this investigation is more stringent. Therefore, those participants reporting a history of non-contact childhood victimization were excluded from the analysis since they met neither the CSA nor non-abuse criteria employed (n=45). Data regarding these participants, nevertheless, is included in the total sample general demographic information.

Of the 338 women included in this study who completed questionnaires during the initial session, a total of 324 returned for follow-up nine weeks later. This represents a return rate of 96%. Due to a clerical error, however, victimization information is unavailable for eight of these participants. Thus, complete data were available on 316
participants.

Demographic information for all participants and for participants by group classification is presented in Table 3. The total sample had a mean age of 19.25. They were primarily first year students (70.4%), Caucasian (92.9%), and heterosexual (95.6%). Approximately half (55.9%) were single, while 41.7% reported themselves living together or partnered. During the course of the study, 56.5% reported having consensual sexual intercourse. The only statistically significant difference among the CSA and non-CSA groups on demographic variables was for sexual orientation. Although primarily still heterosexual (90.0%), the CSA group was more likely to report homosexuality (2.0%) or bisexuality (5.0%) than the non-CSA group. Although this does represent a statistically significant difference (p=.048), because of the very small number of women in the lesbian group, we did not control for this factor.

Insert Table 3

Measures

Participants were asked to complete a number of self-report measures, all of which have been standardized and used with similar populations. A description of each follows:

Demographic Information Form. This brief questionnaire requests information concerning such things as age, ethnic background, marital status, sexual orientation, geographical upbringing, income, and education level (refer to Appendix A).
Modified Traumatic Events Survey. This 54-item measure (cited in Elliott & Briere, 1995) requests information pertaining to the experience of a variety of traumatic life events; information sought includes how upsetting these events were at the time of occurrence and how upsetting their memories are currently. This questionnaire was re-titled “Life Events Survey” and only those 18 items dealing with sexual victimization were used in the current investigation (refer to Appendix B).

Dissociative Experiences Survey — Self-Report. As developed by Bernstein and Putnam (1986), this 28-item self-report measure uses a Likert-type scaling procedure to assess for levels of dissociation (refer to Appendix C). Test-retest reliability for total and subscale scores are reported between .78 and .96; internal consistencies of .96 and .97 were found (Dubester, 1995).

Toronto Alexithymia Scale. This 26-item self-report questionnaire developed by Taylor, Ryan, and Bagby (1985), uses a 5-point Likert scaling procedure to measure the construct of alexithymia (refer to Appendix D). Internal consistency has been reported at .79 and test-retest reliabilities have ranged between .75 and .82 among college students at one and five week intervals, respectively (Taylor, Ryan, & Bagby, 1985). Good construct validity has also been demonstrated for this measure with positive correlations reported between the TAS and the guilt and fear of failure daydreaming (0.44) and the poor attentional control (0.46) subscales of the Short Imaginal Processes Inventory while a negative correlation was reported between the TAS and the positive-constructive daydreaming (-0.38) subscale of this same measure (Bagby, Taylor, & Parker, 1988).

Alcohol Use Measure. This questionnaire (Marlatt, 1994) assesses frequency of both alcohol and drug use (refer to Appendix E). Ten items are used to assess the
frequency and amount of alcohol and drug use. Alcohol use is assessed over the last month’s period whereas drug use is assessed over the last six months. A calendar format is also included to assess (a) the typical number of drinks during the past month that the respondent has consumed each day of the week, and (b) the typical number of hours the respondent has spent drinking each day of the week over the past month. Height, weight, and gender are also requested. For the present analysis, one item was used from this measure to assess alcohol use: “Think of the occasion you drank the MOST in this PAST MONTH. How much did you drink?”.

**UCLA Loneliness Scale (Version 3).** Russell (cited in Russell, 1996) created this 20-item self-report measure using a 4-point Likert scaling procedure to assess degree of loneliness (refer to Appendix F). It has been shown to have good construct validity (with correlations of .65 and .72 with the NYU Loneliness Scale and Differential Loneliness Scale, respectively) and an internal consistency ranging between .89 and .94, with .92 demonstrated within a college population (Russell, 1996).

**Sexual Experiences Survey.** This 13-item self-report measure was designed by Koss and Oros (1982) to detect various degrees of sexual victimization and aggression as a means of identifying potentially hidden sexual assault victims for research participation (refer to Appendix G). Internal consistency of this measure for women is reported as .74 while one-week test-retest reliability has been assessed as .93 (Koss & Gidycz, 1985). To assess for sexual victimization occurring since the first session of this study, items were preceded by the phrase “Since the first session of this study, have you:”. Participants were classified according to the most severe level of victimization endorsed.
Level of Distress. This form asks the rater to assess her level of distress using a 5-point Likert scale. Scores range from 1, not at all distressed, to 5, extremely distressed (refer to Appendix H).

Procedure

Participants were recruited from the introductory psychology research participant pool. Data were collected in small groups of 10 to 12 participants. Goals of the research project, the general research procedure, and information specific to each measure was disseminated in a group format. Additionally, it was emphasized that participants could stop participation at any time without reprisal. After the Informed Consent Form was reviewed (refer to Appendix I) and any questions were answered, participants were asked to sign one copy of the Informed Consent Form for collection. Each participant then retired to a private area to complete the measures. The researcher remained available to answer any questions that arose. Once completed, all measures were collected during a check-in with each participant by the researcher or research assistant. Referrals (refer to Appendix J) were provided generically to each participant. Any participant expressing distress, concern, or negative affect was informally assessed by the researcher, and encouraged to utilize the referrals as appropriate. Appointments were established for the nine-week follow-up session and a reminder card provided. Participants were thanked for their participation and excused as completed.

Names, phone numbers, and date of follow-up appointments were maintained in a separate record. Prior to the scheduled appointment, reminder calls were made to enhance attendance. Additionally, participants were offered an incentive of a raffle ticket to win
movie passes for their participation in the follow-up session. One master list associating participant name and subject number was maintained throughout the course of this investigation. After completion of the study, this list was destroyed.

At the nine-week follow-up session, the same format was followed. Except for the demographics questionnaire, all measures were administered a second time. In addition, the Sexual Experiences Survey was completed, assessing sexual victimization occurring since Time 1. The voluntary nature of the research was further emphasized, along with participants' right to withdraw at any time without negative consequence. A check-in by the researcher or research assistant was carried out as each participant completed the measures. At this time, another listing of referrals was provided along with a debriefing sheet that included the goals and rationale of the research project (refer to Appendix K). As well, any questions, distress, or concerns posed by the participants were addressed as indicated.

Table 4 summarizes the level of distress reported by participants subsequent to completion of measures at each time period. As supported by other investigations (Walker, Newman, Koss, & Bernstein, 1997; Brick, 1999), the majority of participants felt little to no distress as a result of participating in this study. At Time 1, 266 (78.7%) participants reported experiencing no distress, 59 (17.5%) indicated distress somewhere between not at all and moderate, 8 (2.4%) endorsed moderate distress, and 4 (1.2%) reported distress somewhere between moderate and extreme. The level of distress was even lower at Time 2, with 294 (87%) endorsing no distress. Twenty-seven (8.0%) participants reported experiencing distress somewhere between not at all and moderate.
(.6%) were moderately distressed, and 1 (.3%) endorsed distress between moderate and extreme. All participants endorsing moderate or greater distress were assessed by the primary researcher, asked if they would like to process their experience, and specifically encouraged to utilize the referrals provided. None indicated that they required/preferred greater assistance.

Insert Table 4

Results

Victimization During the Semester

Two hundred eighty-one (83.1%) of the participants reported having no incidents of sexual victimization during the semester, whereas 35 (10.4%) reported experiencing some form of victimization (see Table 5). Further, the rates of victimization between the CSA and nonCSA samples differed significantly (p=.004). Similar to previous investigations, the CSA sample was victimized at a 2.5 times greater rate than the nonCSA sample (see Figure 1).

Insert Table 5

Insert Figure 1
Of the total 35 participants endorsing a victimization experience, three reported experiencing sexual contact victimization, defined as physical force utilized in an attempt to secure sexual contact other than intercourse (i.e., kissing, petting). Twenty-three reported experiencing sexual coercion victimization, defined as having sexual intercourse subsequent to feeling pressured by continual arguments, threats to end the relationship, or being misled verbally. Four participants reported attempted rape and five reported having a rape experience. Attempted rape was defined as a failed attempt at sexual intercourse subsequent to force or threat of force; while rape was defined as intercourse (vaginal, anal, or oral) obtained by means of force or threat of force. Identified victimization status was defined as the most severe form of victimization experience reported during the interim period of this study.

Differences Between the CSA and nonCSA Groups at Time 1

Respectively, Figures 2, 3, 4, and 5 represent the assessed mean levels of alexithymia, dissociation, loneliness, and alcohol use for both the CSA and nonCSA samples at the outset of this investigation. Comparisons were carried out examining differences between the CSA and nonCSA groups on each of these four independent variables. (See Table 6.) Results indicate that the groups differed significantly on three of the four constructs assessed. As expected, in each of these areas CSA survivors reported greater difficulties than nonCSA survivors. Specifically, at the beginning of the study, CSA survivors evidenced significantly higher levels of alexithymia (t=-3.200, p=.002), dissociation (t=-3.790, p=.000), and reported alcohol consumption (t=-2.663, p=.008). No differences were found between endorsed levels of loneliness for the two groups (t=-1.278, p=.202).

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Predictors of Victimization within the CSA Group

A logistic regression analysis was utilized to predict revictimization of women with a history of CSA (see Tables 7 and 8). Since there was no hypothesis or support in the literature regarding the differential influence of each variable of interest, dissociation, alexithymia, alcohol use, and loneliness were all entered into the equation simultaneously. For prediction purposes, a classification cutoff of .20 was implemented commensurate with the 20% victimization rate found in this sample.
Using this technique, none of the independent variables assessed at Time 1 were found to predict sexual revictimization. There was a trend, however, for alexithymia to be predictive ($r=.098, p=.090$). Further, the sensitivity and specificity obtained through this analysis were modest at 50.0% and 66.2%, respectively while the overall predictive power using measures assessed at Time 1 was also modest at 63.0%.

Prediction of Victimization in the Overall Sample

A logistic regression was carried out using the combined CSA and non-CSA samples. Childhood victimization status was included as an independent variable along with the four previously identified constructs. Results of this analysis indicated both childhood victimization status and alexithymia at Time 1 were predictive of sexual victimization during the semester ($r=-.10, p=.043$ and $r=.17, p=.005$, respectively). These results indicate that alexithymia accounted for more than twice the variance of childhood victimization status. (See Table 9.) Further, the sensitivity (40.63%), specificity (86.31%), and overall predictive power (80.95%) all evidence moderately high prediction generated through this model (see Table 10). While statistically significant, however, these predictors accounted for a relatively small percent of the total variance (approximately 7%).

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Changes in Predictor Variables over Time Associated with Assault

While the primary goal of this study involved investigating the predictive capacity of dissociation, alexithymia, alcohol use, and loneliness for sexual revictimization, examination was also made regarding changes in these variables following sexual victimization experiences. A number of t-tests were carried out to examine how levels of alexithymia, loneliness, alcohol use, and dissociation changed from Time 1 to Time 2, for those assaulted versus those who were not assaulted. In addition, differences between CSA participants and nonCSA participants over time and current victimization were also examined. These analyses were exploratory and specific comparisons were based on questions of theoretical interest and through examination of group means. The primary questions addressed here were: a) Is adult sexual assault associated with increases in alexithymia, dissociation, alcohol use, and loneliness? and b) is the impact of adult sexual assault different for CSA survivors versus those not previously sexually assaulted? Due to increasing risk for Type I error corresponding to increasing number of analyses, the significance level was established at .01 for these comparisons.

Alexithymia. Figure 6 presents mean levels of alexithymia at Time 1 and Time 2 for CSA and nonCSA, victimized and nonvictimized participants; Table 11 presents
results of specific comparisons made on alexithymia. Significant differences were noted between the nonCSA victimized and nonvictimized groups at Time 1 (p=.009) but not at Time 2 (p=.018), while the CSA victimized and nonvictimized groups showed the opposite effect by evidencing significant differences between groups at Time 2 (p=.001) but not at Time 1 (p=.032). Differences were also noted between the Time 1 and Time 2 assessments of the CSA nonvictimized group (p=.010). There was no significant difference found between either the CSA and nonCSA samples experiencing victimization, or the CSA and nonCSA samples who experienced no victimization during the course of the study.

At the onset of this investigation, the victimized nonCSA sample demonstrated higher levels of alexithymia than the nonvictimized sample (x̄=2.59 and 2.19, respectively). Similar differences were found between the CSA victimized and nonvictimized groups at the end of the study (x̄=2.69 and 2.24, respectively). This latter difference, however, appears attributable to a significant decrease in alexithymia over the course of the study for the CSA nonvictimized group (Time 1 x̄=2.37, Time 2 x̄=2.25).

Generally speaking, CSA participants were more alexithymic than nonCSA
participants. Those CSA survivors who did not experience further sexual victimization became less alexithymic over the course of the semester, while those who did experience sexual victimization remained the same. Hence, it appears that alexithymia does not increase in response to adult sexual victimization. However, sexual victimization in adulthood prevents the individual from improving on alexithymia.

**Dissociation.** Figure 7 presents the mean levels of dissociation for CSA and nonCSA victimized and nonvictimized participants at both time periods. Table 12 contains the results of the comparative analyses carried out specific to the construct of dissociation. The nonvictimized CSA and nonCSA groups differed significantly at the start of the study (p=.002), but did not at study's end (p=.027). Specific to the CSA sample, only the nonvictimized group differed from Time 1 to Time 2 (p=.000). No differences were found between Time 1 and Time 2 of the nonCSA victimized (p=.968), nonCSA nonvictimized (p=.021), or CSA victimized groups (p=.428). Victimized CSA and nonCSA samples did not differ at Time 1 or Time 2 (p=.183 and p=.337, respectively). These results can be summarized as follows: CSA survivors evidence more dissociation than nonCSA survivors; however, if CSA survivors do not experience revictimization, they improve on level of dissociation over time. Those who are victimized do not show increases in dissociation, regardless of CSA status.
Peak alcohol use. Level of recent peak alcohol use by group are presented in Figure 8, while comparisons made between groups are delineated in Table 13. As mentioned earlier, the CSA and nonCSA groups differed significantly in reported peak consumption at Time 1 (p=.008), with those having a CSA history endorsing greater peak use. Specific to those not victimized during the course of this study, significant differences were noted between the CSA and nonCSA samples at Time 1 (p=.002) but not at Time 2 (p=.014). There were no differences noted at either time period between victimized CSA and nonCSA samples (Time 1 p=.310, Time 2 p=.024). Likewise, within each sample, there were no significant differences between alcohol consumption reported at Time 1 and that reported at Time 2.

These results suggest that there was heavy use of alcohol overall among the women in the study. While CSA survivors did evidence greater alcohol use at the beginning of the semester, this difference was not sustained by the end of the semester.
regardless of victimization experience. Generally, peak alcohol use does not appear to increase in response to sexual victimization.

**Loneliness.** Group means for loneliness are presented in Figure 9. Comparisons carried out for the construct of loneliness are detailed in Table 14. While no significant difference was found between the CSA and nonCSA groups at Time 1, significant differences were noted between time periods for each of the specific samples (nonCSA nonvictimized p=.000, nonCSA victimized p=.000, CSA nonvictimized p=.000, and CSA victimized p=.002). In all such cases, mean loneliness scores decreased over the course of the semester. No differences were found comparing nonCSA victimized and nonvictimized samples at either Time 1 or Time 2 (p=.977 and .069, respectively), nor were they found comparing CSA victimized and nonvictimized samples (p=.476 and .019, respectively). While all groups decreased in loneliness over the course of the semester, there was a trend for those women who were sexually victimized to evidence greater levels of loneliness than those who were not, subsequent to their victimization experience.

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Insert Figure 9

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Insert Table 14

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Discussion

Sexual victimization is a major societal problem, not only in terms of the number of individuals affected each year, but the significant psychological ramifications it brings as well. Prevention efforts should not only focus on educating potential perpetrators and rehabilitating known assailants, they should also focus on assisting potential victims in reducing their risk for assault. Although the blame should never be shifted to the victim, there are, perhaps, certain factors within her control which may be key to prevention. This study sought to examine four such potential factors. While previous research has found evidence suggesting that dissociation, alexithymia, alcohol use, and loneliness may all contribute to increased risk for sexual victimization, especially revictimization of CSA survivors, limited support for this supposition was found in this study. None of the factors examined at the outset were found to be predictive of sexual revictimization of CSA survivors. As discussed later, however, this result may be due to insufficient power.

When examining the full sample of women reporting a history of childhood sexual abuse and those indicating no sexually abusive experiences before the age of 18, both alexithymia and CSA were predictive of sexual victimization. Alexithymia actually accounted for twice the variance that CSA accounted for in terms of victimization. Thus, although this model accounted for a small percentage of the total variance, alexithymia may be a better predictor for sexual victimization than CSA. While it has been found that CSA survivors are at 2.4 times greater risk for sexual victimization in adulthood compared to non-CSA survivors (Wyatt, Guthrie, & Notgrass, 1992), perhaps it is the higher levels of alexithymia found in CSA survivors that is the greater contributor.
Although beyond the scope of this investigation, these results would suggest that alexithymia may, in fact, play a moderating role in sexual revictimization.

Alexithymia has three components: difficulty with the identification and description of one’s feelings, a cognitive style that is concrete and reality-based, and an impoverished inner emotional and fantasy life (Taylor, Ryan, & Bagby, 1985). These components may contribute to risk for sexual victimization in different ways. As stated earlier, a woman who demonstrates difficulty describing her feelings may be misinterpreted in a dating or social situation. She may feel that she wishes to stop a sexual advance, but is unable to communicate that intention sufficiently to be effective. Further, she may herself be unable to identify her current emotions. Without a clear understanding of her present emotional state, she will likely not distinctly convey one single message or actually be aware of which message she would like to convey. Here again then, the individual with whom she is socially interacting will receive inconsistent or mixed messages which are difficult to interpret. In such cases, that individual would then be inclined to pursue their own intentions or interpret the ambiguous response consistent with their own desires.

A concrete or reality-based cognitive style suggests the person responds in a tangible cause-effect manner, and has difficulty managing hypothetical situations. Thus, she may find herself unable to think ahead to potential consequences of her actions. She may not discern the connection between engaging in a certain level of sexual intimacy, and that being interpreted as an indication that she wishes or permits a much greater level of intimacy. Being less able to think abstractly, she may not prepare herself for situations
wherein the other individual desires a greater level of intimacy and begins pressuring her in accordance with that desire. The woman with higher levels of alexithymia may not then think ahead to means of escape from such a situation, thereby increasing her risk for sexual victimization.

In this same manner, a woman with a concrete cognitive style places herself at greater risk for sexual assault by a stranger. Although such situations account for a small estimated percentage of sexual assault situations, this lack of mental preparation for hypothetical situations also compromises a woman's ability to respond in a quick and effective manner to threat situations. Instead of a ready repertoire of possible responses (e.g., attempting to fight off her attacker, screaming for help, not placing herself in higher risk situations like being alone at night in an unsafe neighborhood), a woman high in alexithymia may not have contemplated such a situation until she is faced with it. At such juncture, she may then be less likely to manage an effective reaction than someone who has thought abstractly about this scenario and generated alternatives to attempt to protect herself from assault.

Generating hypothetical situations and responses can not only be accomplished at a cognitive level, but also at an emotional level through fantasy. People who are high in alexithymia evidence impoverished fantasy lives. Fantasy is one means for individuals to practice and safely expose themselves to a wide variety of potential social situations. A person with a rich fantasy life may dramatize a number of various scenarios to a variety of social situations before ever embarking on a date. She may then have experienced a number of response sequences, generating information regarding potential reactions in
each setting. Here, she would gain knowledge regarding the likelihood of an interaction transpiring in the manner she espouses through each of the hypothetical situations. As a result, she may be better able to direct her own behavior and responses in accord with that scenario most likely to yield the desired outcome. Women who experience impoverished fantasy lives may not have had the opportunity to do so and may, therefore, have limited repertoires from which to draw in any given interaction. They may also have limited insight into the potential responses of the person with whom they are interacting. Having this limited behavioral repertoire and insight regarding others' behavior may serve to contribute to heightening risk for victimization in a social situation.

Finally, alexithymia has been linked with a deficient inner emotional life. People who have limited inner resources for emotional satisfaction may feel greater desperation in their search for emotional satisfaction external to themselves. In such cases, these people will be less likely to risk rebuking a potential emotional connection by thwarting an attempt at sexual activity. While specific measures of alexithymia were not reported for their sample, this is consistent with Norris, Nurius, and Dimeff's (1996) findings showing that sexually victimized women reported that fear of being rejected posed a barrier to them extricating themselves from a threatening situation.

Thus, high levels of alexithymia may serve to increase a woman's risk for sexual victimization on a number of levels. Hence, prevention efforts targeting these various components of alexithymia may be useful. Assisting women to identify and describe their emotions will enable them to better understand their own desires/intentions and better communicate that to others. Developing thought processes that advance beyond the
concrete here and now would enable women to be proactive in their interactions, to anticipate responses and understand the implications for their own actions.

Nevertheless, while reducing alexithymia may decrease risk for victimization, this construct appears to be fairly stable over time. As such, it may not be especially amenable to short-term interventions. Alexithymia or alexithymic tendencies may be developed during childhood as self-regulation, language acquisition, emotional development/identification and major cognitive development occur. Once such tendencies are established, they may become ingrained, serving to function in more of a trait-like manner. Strategies designed to reduce levels of alexithymia may consequently require longer-term and more intensive intervention efforts than that which can be accomplished in a short, psychoeducational format.

That said, however, alexithymia did decrease over the course of the semester for those CSA survivors who did not experience revictimization. This finding may suggest that there is an improvement in the ability to think abstractly associated with the demands of post-secondary education. Another possibility is that heightened social demands associated with college life contribute to a greater awareness of emotions and greater facility of emotional expression. In either case, this does suggest that some remediation of alexithymia may occur.

In addition to predicting revictimization, this study examined changes in alexithymia, loneliness, alcohol use, and dissociation in the two groups (nonCSA and CSA) over time and as a function of whether victimization occurred during the semester. Consistent with numerous other studies (e.g., Collings, 1997; Fergusson, Horwood, &
Lunskey, 1997; Briere & Runtz, 1987), results indicate that CSA survivors manifested greater symptomatology than nonCSA survivors in the areas of alexithymia, dissociation, and alcohol use. These symptoms likely result from the CSA experience; however, this study cannot rule out the possibility that family dysfunction or other factors associated with CSA influence these symptoms.

The only difference not identified between the two groups was on loneliness. A difference, perhaps, that was not found due to the overarching normative nature of heightened loneliness associated with immersion in a novel or strange environment. The majority of this sample was first year students who may not have had opportunity by the start of the study to acclmate and make friends. As would be expected, then, significant reductions in loneliness were noted for all subgroups by the end of the semester. Contrary to the expectations of this study, results do not support the hypothesis that loneliness contributes to heightened risk for sexual victimization.

Although there was a preponderance of heavy alcohol use throughout the groups, similar to other studies (e.g., Hulme & Grove, 1994; Sedney & Brooks, 1984) this investigation found greater use among CSA survivors. This difference, however, was not maintained over the course of the study, a result of the nonCSA sample increasing their consumption. This may be a reflection of the CSA sample engaging in more risk-taking behaviors early and the nonCSA sample subsequently “catching up” as they enter a normal phase of adolescent exploration and experimentation. There was no evidence in this investigation that either increased alcohol consumption led to sexual victimization, or was a consequent thereof.
Also consistent with other investigations (Briere & Runtz, 1987, 1988; Bagley & Ramsey, 1986), this study found dissociative symptomatology to be higher among CSA survivors compared to the nonCSA group. Further, for those survivors who did not experience revictimization, their levels of dissociation decreased over the course of the semester. It may be that the CSA survivors who were not revictimized had opportunity to change environments and remove themselves from reminders of their victimizing experience, thereby affording them the opportunity to ameliorate the need for continued dissociation. This investigation did not find higher levels of dissociation to be a risk factor for victimization, nor was there support for the contention that dissociation increases in response to adult sexual victimization.

Finally, consistent with the results of the logistic regression analysis, higher levels of alexithymia were found for both CSA and nonCSA victimized groups. The results of this study, however, are not consistent with those of Cloitre, Scarvalone, and Difede (1997) who found higher rates of alexithymia among a revictimized sample compared to both women with a single adolescent or adult assault experience and those with no reported history of sexual victimization. This study found no differences between levels of alexithymia for the nonCSA victimized (single assault experience) and CSA victimized (revictimized) samples at either time period.

This discrepancy between the two studies may be due to the recency of the victimizing or revictimizing experience in the current investigation. The Cloitre, Scarvalone, and Difede (1997) sample was not specific to recent assault victims; in fact, their revictimized group reported a mean of 114 months since the rape experience while...
their single assault group reported 103 months on average since assault. In contrast, the current investigation examined victimization and revictimization occurring within the nine-week course of the study. Hence, taking both studies into account, this suggests that differences in alexithymia found between singly and multiply victimized women may occur over time as opposed to directly subsequent to the victimization experience.

In summary, although differences were noted overall between the CSA and non-CSA groups, only one variable heightened risk for sexual victimization: alexithymia. Further, CSA survivors not revictimized showed improvement on alexithymia and dissociation, however, none of the predictor variables increased as a result of victimization. Hence, this study has informed our knowledge base and overall suggests a possible new direction for risk reduction efforts: namely, decreasing alexithymia. Much more information, however, is needed in this area, given the limited amount of variance accounted for.

**Limitations to this Study**

Although the results reported in this investigation are noteworthy, there are certain limitations to this study as well. These limitations include the fact that all measures were self-report and that the assessment of CSA, as well as victimization occurring during the course of the study, was retrospective in nature. All self-report measures include the possibility that respondents will misunderstand questions, intentionally lie, or not respond carefully or forget and unintentionally misrepresent their experience as a result. Asking respondents to report on their experiences 20 or more years in the past compromises the accuracy of their response.
However, given the emotional intensity often associated with circumstances of abuse, it is unlikely that, other than in cases of repressed memory or willful misrepresentation, the victim’s response will be significantly incorrect to place them into the wrong dichotomous CSA/nonCSA classification. The SES is designed to detect unacknowledged victims of sexual assault through its highly behaviorally descriptive items. Correlation reported between SES responses and that obtained through interview is .74, with less than one-fourth of discrepancies resulting in a change in dimensional classification of level of victimization (Koss & Gidycz, 1985).

Another limitation of this study pertains to its generalizability. The sample is comprised of post-secondary students, largely Caucasian first-year students who were raised in non-metropolitan regions. While the victimization rate for 16- to 24-year-olds is estimated as four times the average for all other age groups of women (Koss, Gidycz, & Wisniewski, 1987), those women who are pursuing post-secondary educations may be significantly dissimilar to those who are not. It can be posited that those women with the greatest compromise in level of functioning would likely not be attending college. Additionally, higher socioeconomic and ethnic majority status, and higher cognitive capabilities or academic achievement are greater represented among college samples. Thus, findings reported here may not generalize outside of college populations. As well, the University of Montana does not boast the relatively high levels of ethnic diversity found on college campuses located in more metropolitan areas or different geographic regions. This may further serve to limit the generalizability of the results reported in this investigation.
This study is also limited by a sample size that may have been insufficient for a logistic regression analysis. There were 92 CSA survivors in this study. Guidelines for most applications of logistic regression indicate a minimum of 50 cases per predictor variable (Aldrich & Nelson, 1984). This investigation examined four independent variables in its analysis of sexual revictimization, hence, sample size may have been insufficient to detect any significant differences in actuality.

The definition of CSA employed in this study may also be a limitation. CSA was defined as sexual touch before the age of 18 obtained via force or threat of force, or that involving anyone five or more years older regardless of means obtained. While it is debatable whether sexual touch obtained in a dating situation between a 17-year-old minor and a 22-year-old adult is, indeed, CSA, it most likely does not present the same psychological ramifications of sexual touch occurring between a much younger child and her father. Hence, including consensual situations between dating partners and non-consensual instances of well-defined abuse in the classification of CSA may dilute the statistical viability of those characteristics most leading to heightened risk for sexual revictimization of CSA survivors. While 37 of the 92 CSA survivors identified in this study reported being over the age of 14 when they experienced sexual touch with someone five or more years older, only 6 of these survivors did not also identify another victimizing experience such as having someone less than five years older use force or threats to engage in sexual touch. Further, of these remaining six participants, information regarding the consensual nature of their experiences was not specifically obtained.

Further, there is some indication that level of severity of abuse contributes to adult
outcome (Browne & Finkelhor, 1986; Banyard & Williams, 1996). Hence, level of severity may influence those factors which heighten risk for revictimization. This study does not distinguish between CSA victims of coercion, threat of force, or implementation of force, nor does it distinguish between CSA victims who experienced fondling versus those that experienced penetration. Perhaps a larger study would be able to maintain differential categories of victimization for analysis instead of collapsing all CSA survivors into one grouping.

Another limitation of this study involves variability in the timing of past sexual abuse. The CSA group was comprised of women with varied recency of victimization. Some had been sexually abused in early childhood while others met the criteria for CSA within the past year. In their prospective analysis, Gidycz, Hanson, and Layman (1995) found a relationship between recency of previous victimization and risk for revictimization. This factor was not included in the current investigation.

Additionally, measurement of the predictor variables in relation to victimization was not differentiated. This may be especially pronounced regarding the alcohol use measure. Participants were asked to report on the occasion they drank the most in the past month. When assessing revictimization during the course of the study, there is no way of differentiating whether the incident wherein they drank the most occurred before, during, or after their victimization experience. Hence, what might be assessed as a consequent of the victimization (i.e., the increased drinking) may in fact be a contributor to it.

Finally, although this study limits itself to the investigation of sexual victimization within a female population, it is not the author’s intent to discount the victimization of
males. Surely male victims present some of the same sequelae reported in female victims. However, there may also be distinctions. Nevertheless, females are far more frequently victims of sexual assault. Consequently, the research focuses there. Once we have a greater understanding of sexual revictimization in women, perhaps investigators will turn their attention to the significantly less rampant victimization of males.

The above limitations taken into account, the current investigation suggests that alexithymia, a construct shown to be associated with adult outcomes of CSA, may be an important factor contributing to heightened risk for sexual victimization. Replication of this finding is needed. Additionally, experimental examinations of sexual assault risk awareness programs incorporating remediation efforts towards alexithymia would be beneficial. This demands that systematic means of reducing levels of alexithymia be found. In 1994, it was estimated that 316,000 U.S. women experienced rape/attempted rape each day (Fullpower, 1996). Information which informs our prevention efforts is of paramount importance in the establishment of more effective programs and the eradication of this problem.
References


### Sequelea of Adult Survivors of Childhood Sexual Abuse

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<tr>
<th>Psychological Challenges</th>
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<th>Circumstantial Proclivities</th>
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### Table 2

**Effects of Adult Sexual Victimization**

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<td>Sexual problems&lt;sup&gt;11,12,13&lt;/sup&gt;</td>
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<tr>
<td>Depression&lt;sup&gt;6,7,11,14&lt;/sup&gt;</td>
<td>Confusion/impaired concentration&lt;sup&gt;6,11&lt;/sup&gt;</td>
</tr>
<tr>
<td>Anger&lt;sup&gt;8,9&lt;/sup&gt;</td>
<td>General fearfulness&lt;sup&gt;5,7,11&lt;/sup&gt;</td>
</tr>
<tr>
<td>Decreased pleasure in daily activities/hobbies&lt;sup&gt;10,14&lt;/sup&gt;</td>
<td>Economic difficulties&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td>Sleep problems&lt;sup&gt;11&lt;/sup&gt;</td>
<td>Fatigue&lt;sup&gt;11&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

<sup>1</sup>Rothbaum, Foa, Riggs, Murdock, & Walsh (1992).  
<sup>2</sup>Resnick, Kilpatrick, Dansky, Saunders, & Best (1993).  
<sup>3</sup>Calhoun, Atkeson, & Resick (1982).  
<sup>4</sup>Veronen & Kilpatrick (1980).  
<sup>5</sup>Kilpatrick, Resick, & Veronen (1981).  
<sup>7</sup>Atkeson, Calhoun, Resick, & Ellis (1982).  
<sup>8</sup>Hyer, O’Leary, Saucer, Blount, Harrison, & Boudewyns (1986).  
<sup>10</sup>Resick, Calhoun, Atkeson, & Ellis (1981).  
<sup>11</sup>Nadelson, Notman, Zackson, & Gornick (1982).  
<sup>13</sup>Becker, Skinner, Abel, & Treacy (1982).  
<sup>14</sup>Ellis, Atkeson, & Calhoun (1981).
<table>
<thead>
<tr>
<th></th>
<th>TOTAL (n=338)</th>
<th>nonCSA (n=193)</th>
<th>CSA (n=100)</th>
</tr>
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<tbody>
<tr>
<td><strong>AGE</strong></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>X</td>
<td>19.2544</td>
<td>19.1192</td>
<td>19.4000</td>
</tr>
<tr>
<td>SD</td>
<td>1.8506</td>
<td>1.7711</td>
<td>1.9949</td>
</tr>
<tr>
<td><strong>YEAR IN SCHOOL</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st</td>
<td>70.4% (n=238)</td>
<td>72.5% (n=140)</td>
<td>70.0% (n=70)</td>
</tr>
<tr>
<td>2nd</td>
<td>16.9% (n=57)</td>
<td>17.1% (n=33)</td>
<td>17.0% (n=17)</td>
</tr>
<tr>
<td>3rd</td>
<td>9.5% (n=32)</td>
<td>6.2% (n=12)</td>
<td>12.0% (n=12)</td>
</tr>
<tr>
<td>4th</td>
<td>2.1% (n=7)</td>
<td>2.6% (n=5)</td>
<td>1.0% (n=1)</td>
</tr>
<tr>
<td>other</td>
<td>1.2% (n=4)</td>
<td>1.6% (n=3)</td>
<td></td>
</tr>
<tr>
<td><strong>RACE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>African American</td>
<td>0.6% (n=2)</td>
<td>1.0% (n=2)</td>
<td>0.0% (n=0)</td>
</tr>
<tr>
<td>Caucasian</td>
<td>92.9% (n=314)</td>
<td>93.3% (n=180)</td>
<td>91.0% (n=91)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>1.5% (n=5)</td>
<td>1.6% (n=3)</td>
<td>1.0% (n=1)</td>
</tr>
<tr>
<td>Native American</td>
<td>2.1% (n=7)</td>
<td>2.1% (n=4)</td>
<td>3.0% (n=3)</td>
</tr>
<tr>
<td>Asian American</td>
<td>0.6% (n=2)</td>
<td>0.0% (n=0)</td>
<td>2.0% (n=2)</td>
</tr>
<tr>
<td>other</td>
<td>2.4% (n=8)</td>
<td>2.1% (n=4)</td>
<td>3.0% (n=3)</td>
</tr>
<tr>
<td><strong>GEOGRAPHICAL ORIGINS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>rural/ranch</td>
<td>9.8% (n=33)</td>
<td>11.4% (n=22)</td>
<td>8.0% (n=8)</td>
</tr>
<tr>
<td>small town</td>
<td>17.5% (n=59)</td>
<td>15.5% (n=30)</td>
<td>23.0% (n=23)</td>
</tr>
<tr>
<td>town</td>
<td>30.2% (n=102)</td>
<td>29.5% (n=57)</td>
<td>30.0% (n=30)</td>
</tr>
<tr>
<td>small city</td>
<td>31.1% (n=105)</td>
<td>30.1% (n=58)</td>
<td>30.0% (n=30)</td>
</tr>
<tr>
<td>metropolitan area</td>
<td>11.5% (n=39)</td>
<td>13.5% (n=26)</td>
<td>9.0% (n=9)</td>
</tr>
<tr>
<td><strong>RELATIONSHIP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>single</td>
<td>55.9% (n=189)</td>
<td>56.0% (n=108)</td>
<td>58.0% (n=58)</td>
</tr>
<tr>
<td>married</td>
<td>1.8% (n=6)</td>
<td>2.1% (n=4)</td>
<td>2.0% (n=2)</td>
</tr>
<tr>
<td>cohabitating/partnered</td>
<td>41.7% (n=141)</td>
<td>41.4% (n=80)</td>
<td>39.0% (n=39)</td>
</tr>
<tr>
<td>separated/divorced</td>
<td>0.6% (2)</td>
<td>0.5% (n=1)</td>
<td>1.0% (n=1)</td>
</tr>
<tr>
<td><strong>SEXUAL ORIENTATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>heterosexual</td>
<td>95.6% (n=323)</td>
<td>97.4% (n=188)</td>
<td>90.0% (n=90)*</td>
</tr>
<tr>
<td>homosexual</td>
<td>1.5% (n=5)</td>
<td>1.6% (n=3)</td>
<td>2.0% (n=2)</td>
</tr>
<tr>
<td>bisexual</td>
<td>1.8% (n=6)</td>
<td>0.5% (n=1)</td>
<td>5.0% (n=5)</td>
</tr>
<tr>
<td>missing data</td>
<td>1.2% (n=4)</td>
<td>0.5% (n=1)</td>
<td>3.0% (n=3)</td>
</tr>
<tr>
<td><strong>NUMBER OF TIMES MARRIED</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>once</td>
<td>2.1% (n=7)</td>
<td>2.1% (n=4)</td>
<td>3.0% (n=3)</td>
</tr>
<tr>
<td>never</td>
<td>97.9% (n=331)</td>
<td>97.9% (n=189)</td>
<td>97.0% (n=97)</td>
</tr>
<tr>
<td><strong>CHILDREN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no</td>
<td>94.7% (n=320)</td>
<td>95.3% (n=184)</td>
<td>94.0% (n=94)</td>
</tr>
<tr>
<td>yes</td>
<td>4.7% (n=16)</td>
<td>4.1% (n=8)</td>
<td>6.0% (n=6)</td>
</tr>
<tr>
<td>missing data</td>
<td>0.6% (n=2)</td>
<td>0.5% (n=1)</td>
<td></td>
</tr>
<tr>
<td><strong>PARENTS’ DIVORCE</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no</td>
<td>67.2% (n=227)</td>
<td>68.4% (n=132)</td>
<td>66.0% (n=66)</td>
</tr>
<tr>
<td>yes</td>
<td>31.1% (n=105)</td>
<td>29.0% (n=56)</td>
<td>33.0% (n=33)</td>
</tr>
<tr>
<td>missing data</td>
<td>1.8% (n=6)</td>
<td>2.6% (n=5)</td>
<td>1.0% (n=1)</td>
</tr>
<tr>
<td><strong>BEFORE AGE 18</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>no</td>
<td>37.0% (n=125)</td>
<td>38.9% (n=75)</td>
<td>28.0% (n=28)</td>
</tr>
<tr>
<td>yes</td>
<td>65.5% (n=191)</td>
<td>54.9% (n=106)</td>
<td>64.0% (n=64)</td>
</tr>
<tr>
<td>missing data</td>
<td>6.5% (n=22)</td>
<td>6.2% (n=12)</td>
<td>8.0% (n=8)</td>
</tr>
</tbody>
</table>

*p<.05

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Table 4

Reported Level of Distress

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Moderately distressed</th>
<th>Extremely distressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time 1</td>
<td>78.7%</td>
<td>17.5%</td>
<td>2.7% 1.2% 0.0%</td>
</tr>
<tr>
<td></td>
<td>(n=266)</td>
<td>(n=59)</td>
<td>(n=2) (n=4) (n=0)</td>
</tr>
<tr>
<td>Time 2</td>
<td>87.0%</td>
<td>8.0%</td>
<td>0.6% 0.3% 0.0%</td>
</tr>
<tr>
<td></td>
<td>(n=294)</td>
<td>(n=27)</td>
<td>(n=2) (n=1) (n=0)</td>
</tr>
</tbody>
</table>
Table 5

<table>
<thead>
<tr>
<th>Level of Victimization Endorsed</th>
<th>Sample SES(^1) questions</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Victimization</td>
<td>— Have you had sexual intercourse with a man [woman] when you both wanted to?</td>
<td>83.1%</td>
</tr>
<tr>
<td></td>
<td>— Have you had a man [woman] misinterpret the level of sexual intimacy you desired?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Have you been in a situation where a man [woman] became so sexually aroused that you felt it was useless to stop him [her] even though you did not want to have sexual intercourse?</td>
<td></td>
</tr>
<tr>
<td>Sexual Contact</td>
<td>— Have you been in a situation where a man [woman] used some degree of physical force to try to make you engage in kissing or petting when you didn’t want to?</td>
<td>0.9%</td>
</tr>
<tr>
<td>Sexual Coercion</td>
<td>— Have you had sexual intercourse with a man [woman] when you didn’t really want to because you felt pressured by his [her] continual arguments?</td>
<td>6.8%</td>
</tr>
<tr>
<td></td>
<td>— Have you had sexual intercourse with a man [woman] even though you didn’t really want to because he [she] threatened to end your relationship otherwise?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Have you found out that a man [woman] had obtained sexual intercourse with you by saying things he [she] didn’t really mean?</td>
<td></td>
</tr>
<tr>
<td>Attempted Rape</td>
<td>— Have you been in a situation where a man [woman] tried to get sexual intercourse with you when you didn’t want to by threatening to use physical force if you didn’t cooperate, but for various reasons sexual intercourse did not occur?</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td>— Have you been in a situation where a man [woman] used some degree of physical force to try to get you to have sexual intercourse with him [her] when you didn’t want to, but for various reasons sexual intercourse did not occur?</td>
<td></td>
</tr>
<tr>
<td>Rape</td>
<td>— Have you had sexual intercourse with a man [woman] when you didn’t want to because he [she] threatened to use physical force when you didn’t cooperate?</td>
<td>1.5%</td>
</tr>
<tr>
<td></td>
<td>— Have you had sexual intercourse with a man [woman] when you didn’t want to because he [she] used some degree of physical force?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Have you been in a situation where a man [woman] obtained sexual acts with you such as anal or oral intercourse when you didn’t want to by using threats or physical force?</td>
<td></td>
</tr>
<tr>
<td></td>
<td>— Have you been raped?</td>
<td></td>
</tr>
</tbody>
</table>

\(^1\)Sexual Experiences Survey
Table 6

Differences Between CSA and NonCSA Samples at Time 1

<table>
<thead>
<tr>
<th>Variable</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alexithymia</td>
<td>-3.200</td>
<td>291</td>
<td>.002*</td>
</tr>
<tr>
<td>Dissociation</td>
<td>-3.790</td>
<td>158.49</td>
<td>.000*</td>
</tr>
<tr>
<td>Alcohol consumption</td>
<td>-2.663</td>
<td>291</td>
<td>.008*</td>
</tr>
<tr>
<td>Loneliness</td>
<td>-1.278</td>
<td>291</td>
<td>.202</td>
</tr>
</tbody>
</table>

*significant at .01
Table 7

Logistic Regression Analysis including CSA Sample predicting Revictimization during the Semester using Time 1 Measures of Dissociation, Alexithymia, Alcohol Use, and Loneliness

<table>
<thead>
<tr>
<th>Variable</th>
<th>R</th>
<th>R²</th>
<th>e^b</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation</td>
<td>.0000</td>
<td>.0000</td>
<td>.8519</td>
<td>1.0063</td>
</tr>
<tr>
<td>Loneliness</td>
<td>.0000</td>
<td>.0000</td>
<td>1.0138</td>
<td>.8423</td>
</tr>
<tr>
<td>Alexithymia</td>
<td>.0980</td>
<td>.0096</td>
<td>2.4283</td>
<td>.0900</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>.0000</td>
<td>.0000</td>
<td>.8691</td>
<td>.3800</td>
</tr>
</tbody>
</table>
Table 8

Classification Table of Revictimization of CSA Sample

<table>
<thead>
<tr>
<th>Observed</th>
<th>Predicted</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>No victimization</td>
<td>49</td>
<td>25</td>
</tr>
<tr>
<td>Victimization</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Overall</td>
<td>63.04%</td>
<td></td>
</tr>
</tbody>
</table>

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Table 9

Logistic Regression Analysis including Full Sample predicting Victimization during the Semester using CSA Status and Time 1 Measures of Dissociation, Alexithymia, Alcohol Use, and Loneliness

<table>
<thead>
<tr>
<th>Variable</th>
<th>R</th>
<th>R²</th>
<th>e^b</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dissociation</td>
<td>.0000</td>
<td>.0000</td>
<td>1.0087</td>
<td>.7329</td>
</tr>
<tr>
<td>Alexithymia</td>
<td>.1726</td>
<td>.0298</td>
<td>2.9585</td>
<td>.0050**</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>.0000</td>
<td>.0000</td>
<td>1.0564</td>
<td>.6295</td>
</tr>
<tr>
<td>Loneliness</td>
<td>.0000</td>
<td>.0000</td>
<td>.9715</td>
<td>.5877</td>
</tr>
<tr>
<td>CSA status</td>
<td>-.1034</td>
<td>.0107</td>
<td>.4386</td>
<td>.0426*</td>
</tr>
</tbody>
</table>

*significant at .05
**significant at .01
Table 10
Classification Table of Victimization Including Full Sample using CSA Status and Time

Measures of Dissociation, Alexithymia, Alcohol Use, and Loneliness

<table>
<thead>
<tr>
<th>Observed</th>
<th>No victimization</th>
<th>Victimization</th>
<th>Percent Correct</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>208</td>
<td>33</td>
<td>86.31%</td>
</tr>
<tr>
<td></td>
<td>19</td>
<td>13</td>
<td>40.63%</td>
</tr>
<tr>
<td>Overall</td>
<td></td>
<td></td>
<td>80.95%</td>
</tr>
</tbody>
</table>
Table 11

T-Test Comparisons for Alexithymia

<table>
<thead>
<tr>
<th>Comparison</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonCSA nonvictimized versus CSA nonvictimized at Time 1</td>
<td>-2.381</td>
<td>239</td>
<td>.018</td>
</tr>
<tr>
<td>NonCSA nonvictimized versus CSA nonvictimized at Time 2</td>
<td>-0.714</td>
<td>239</td>
<td>.476</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 1</td>
<td>-0.530</td>
<td>30</td>
<td>.600</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 2</td>
<td>-0.660</td>
<td>30</td>
<td>.514</td>
</tr>
<tr>
<td>NonCSA nonvictimized versus nonCSA victimized at Time 1</td>
<td>-2.652</td>
<td>179</td>
<td>.009*</td>
</tr>
<tr>
<td>NonCSA nonvictimized versus nonCSA victimized at Time 2</td>
<td>-2.392</td>
<td>179</td>
<td>.018</td>
</tr>
<tr>
<td>CSA nonvictimized versus CSA victimized at Time 1</td>
<td>-2.181</td>
<td>90</td>
<td>.032</td>
</tr>
<tr>
<td>CSA nonvictimized versus CSA victimized at Time 2</td>
<td>-3.329</td>
<td>90</td>
<td>.001*</td>
</tr>
<tr>
<td>CSA nonvictimized at Time 1 versus CSA nonvictimized at Time 2</td>
<td>2.641</td>
<td>73</td>
<td>.010*</td>
</tr>
</tbody>
</table>

*significant at .01

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Table 12

T-Test Comparisons for Dissociation

<table>
<thead>
<tr>
<th>Comparison</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonCSA nonvictimized versus CSA nonvictimized at Time 1</td>
<td>-3.238</td>
<td>115.956</td>
<td>.002*</td>
</tr>
<tr>
<td>NonCSA nonvictimized versus CSA nonvictimized at Time 2</td>
<td>-2.238</td>
<td>117.266</td>
<td>.027</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 1</td>
<td>-1.362</td>
<td>30</td>
<td>.183</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 2</td>
<td>-.976</td>
<td>30</td>
<td>.337</td>
</tr>
<tr>
<td>NonCSA nonvictimized at Time 1 versus at Time 2</td>
<td>2.327</td>
<td>166</td>
<td>.021</td>
</tr>
<tr>
<td>NonCSA victimized at Time 1 versus at Time 2</td>
<td>-.041</td>
<td>13</td>
<td>.968</td>
</tr>
<tr>
<td>CSA nonvictimized at Time 1 versus at Time 2</td>
<td>4.187</td>
<td>73</td>
<td>.000*</td>
</tr>
<tr>
<td>CSA victimized at Time 1 versus at Time 2</td>
<td>0.812</td>
<td>17</td>
<td>.428</td>
</tr>
</tbody>
</table>

*significant at .01
Table 13

T-Test Comparisons for Peak Alcohol Use Endorsed

<table>
<thead>
<tr>
<th>Comparison</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>NonCSA nonvictimimized versus CSA nonvictimimized at Time 1</td>
<td>-3.071</td>
<td>239</td>
<td>.002*</td>
</tr>
<tr>
<td>NonCSA nonvictimimized versus CSA nonvictimimized at Time 2</td>
<td>-2.481</td>
<td>239</td>
<td>.014</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 1</td>
<td>1.032</td>
<td>30</td>
<td>.310</td>
</tr>
<tr>
<td>NonCSA victimized versus CSA victimized at Time 2</td>
<td>2.371</td>
<td>30</td>
<td>.024</td>
</tr>
<tr>
<td>NonCSA nonvictimimized at Time 1 versus at Time 2</td>
<td>-1.210</td>
<td>166</td>
<td>.228</td>
</tr>
<tr>
<td>NonCSA victimized at Time 1 versus at Time 2</td>
<td>-1.794</td>
<td>13</td>
<td>.096</td>
</tr>
<tr>
<td>CSA nonvictimimized at Time 1 versus at Time 2</td>
<td>.244</td>
<td>73</td>
<td>.808</td>
</tr>
<tr>
<td>CSA victimized at Time 1 versus at Time 2</td>
<td>-.160</td>
<td>17</td>
<td>.875</td>
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</tbody>
</table>

*significant at .01
Table 14

T Test Comparisons for Loneliness

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<th>Comparison</th>
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<tbody>
<tr>
<td>NonCSA nonvictimized versus nonCSA victimized at Time 1</td>
<td>.029</td>
<td>179</td>
<td>.977</td>
</tr>
<tr>
<td>NonCSA nonvictimized versus nonCSA victimized at Time 2</td>
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<td>.069</td>
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<td>CSA nonvictimized versus CSA victimized at Time 1</td>
<td>-.716</td>
<td>90</td>
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<td>CSA nonvictimized versus CSA victimized at Time 2</td>
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<td>CSA nonvictimized at Time 1 versus at Time 2</td>
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<td>73</td>
<td>.000*</td>
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<td>CSA victimized at Time 1 versus at Time 2</td>
<td>3.617</td>
<td>17</td>
<td>.002*</td>
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</table>

*significant at .01
Figure 1. Sexual Victimization Status during One Academic Semester by CSA History.
Figure 2. Mean Levels of Alexithymia at Time 1 by Group Classification.
Figure 3. Mean Levels of Dissociation at Time 1 by Group Classification.
Figure 4. Mean Levels of Loneliness at Time 1 by Group Classification.
Figure 5. Mean Levels Alcohol Use at Time 1 by Group Classification.
Figure 6. Mean Levels of Alexithymia by Time and Group Classification.
Figure 7. Mean Levels of Dissociation by Time and Group Classification.
Figure 8. Percent of Heavy Alcohol Users by Time and Group Classification.
Figure 9. Degree of Loneliness Endorsed by Time and Group Classification.
APPENDIX A

Demographic Information Form

These questions are intended to obtain some general information about you:

1. What is your age? ___________

2. What year are you in college?
   ________ first year  ________ second year
   ________ third year  ________ fourth year
   other (please specify) ___________________________

3. What is your racial/ethnic background? (Please check all that apply):
   African American ________  White/Caucasian ________
   Hispanic ________  Native American ________
   Asian American ________  other (please specify) ________

4. What best describes the type of area you grew up in?
   Rural/ranch ________  Small town (less than 2,000) ______
   Town (2,000-40,000) ________  Small city (40,000-100,000) ______
   Metropolitan area (larger than 100,000) ______

5. What best describes your current relationship status?
   Single ____  Married ____  Living together ____
   Partnered ____  Separated ____  Divorced ____

6. What is your sexual orientation?
   Heterosexual ____  Homosexual ____  Bisexual ____

7. If you have been married, how many times have you been married? __

8. Do you have any biological or adopted children? Yes ____  No ____

9. If yes, how many? ______

10. Did you experience the divorce of your parents before you turned 18?
    (If you did not grow up with your biological parents, please answer this
    question with reference to your primary care givers):

    Yes ____  No ____
APPENDIX B

LIFE EVENTS SURVEY

The following survey asks about things that may have happened to you in the past. Please answer all of the questions that you can, as honestly as possible.

Throughout the survey, you will be asked how upsetting various events in your life have been for you. Respond on a scale of 0 to 3, where 0 = not at all upsetting and 3 = very upsetting. If more than one instance of a given event occurred, please answer the subsequent questions with regard to the worst time it happened.

<table>
<thead>
<tr>
<th>Your age the first time it happened</th>
<th>Your age the last time it happened</th>
<th>How many times did it happen</th>
<th>How upsetting was it when it happened</th>
<th>How upsetting is the memory of it now</th>
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<tr>
<td>1</td>
<td>2-5</td>
<td>6-10</td>
<td>11-20</td>
<td>+20</td>
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<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
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</tbody>
</table>

1. Since you were 18, have you been raped (defined as being threatened or physically forced to have oral, anal, or vaginal intercourse) by someone who was not a spouse, lover, or data?
   
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<thead>
<tr>
<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
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</tbody>
</table>

2. Since you were 18, have you been raped (defined as being threatened or physically forced to have oral, anal, or vaginal intercourse) by a spouse, lover, or data?
   
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<th>No</th>
<th>Yes</th>
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<tbody>
<tr>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
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</tbody>
</table>

3. Since you were 18, have you been sexually assaulted (sexual contact that did not include intercourse but occurred because you were threatened or forced) by someone who was not a spouse, lover, or data?
   
<table>
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<th>No</th>
<th>Yes</th>
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<tr>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
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</table>

4. Since you were 18, have you been sexually assaulted (sexual contact that did not include intercourse but occurred because you were threatened or forced) by a spouse, lover, or data?
   
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<th>No</th>
<th>Yes</th>
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<tr>
<td>0 1 2 3</td>
<td>0 1 2 3</td>
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</table>
5. **Before you were 18**, were you ever exposed to inappropriate comments about sex or sexual parts?

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<th>Age the first time it happened</th>
<th>Age the last time it happened</th>
<th>How many times did it happen</th>
<th>How upsetting it was when it happened</th>
<th>How upsetting it is to you now</th>
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<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>1</td>
<td>2-5</td>
<td>6-10</td>
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</table>

With how many different people did this happen?  
What was their relationship to you? (Check all that apply)

- Father/Mother  
- Stepfather/Stepmother  
- Other family member  
- Friend or peer  
- Professional (coach, minister/priest/rabbi, therapist/counselor)  
- Other

6. **Before you were 18**, were you ever exposed to someone "flashing" or exposing their sexual parts to you?

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<th>Age the first time it happened</th>
<th>Age the last time it happened</th>
<th>How many times did it happen</th>
<th>How upsetting it was when it happened</th>
<th>How upsetting it is to you now</th>
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<tr>
<td>No</td>
<td>Yes</td>
<td>1</td>
<td>2-5</td>
<td>6-10</td>
</tr>
</tbody>
</table>

With how many different people did this happen?  
What was their relationship to you? (Check all that apply)

- Father/Mother  
- Stepfather/Stepmother  
- Other family member  
- Friend or peer  
- Professional (coach, minister/priest/rabbi, therapist/counselor)  
- Other
7. **Before you were 18, did anyone ever spy on you or watch you while bathing, dressing, or using the bathroom?**

   - Your age the first time it happened
   - Your age the last time it happened
   - How many times did it happen
   - How upsetting was it when it happened
   - How upsetting is the memory of it now

   No Yes

   With how many different people did this happen?

   - No
   - Yes

   What was their relationship to you? (Check all that apply)
   - Father/Mother
   - Brother/Sister
   - Stepfather/Stepmother
   - Stepbrother/Stepsister
   - Other family member
   - Parents' friend
   - Friend or peer
   - Stranger
   - Professional (coach, minister/priest/rabbi, doctor, teacher, therapist/counselor)
   - Other

8. **Before you were 18, were you ever forced or coerced to watch sexual acts, including masturbation and/or sex between people?**

   - Your age the first time it happened
   - Your age the last time it happened
   - How many times did it happen
   - How upsetting was it when it happened
   - How upsetting is the memory of it now

   No Yes

   With how many different people did this happen?

   - No
   - Yes

   What was their relationship to you? (Check all that apply)
   - Father/Mother
   - Brother/Sister
   - Stepfather/Stepmother
   - Stepbrother/Stepsister
   - Other family member
   - Parents' friend
   - Friend or peer
   - Stranger
   - Professional (coach, minister/priest/rabbi, doctor, teacher, therapist/counselor)
   - Other
9. **Before you were 18**, were you ever made to pose for sexy or suggestive photographs?

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<td>6-10</td>
<td>11-20</td>
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With how many different people did this happen?

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<tr>
<th>What was their relationship to you? (Check all that apply)</th>
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<tr>
<td>Father/Mother</td>
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<td>Stepfather/Stepmother</td>
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<td>Other family member</td>
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<td>Friend or peer</td>
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<td>Professional (coach)</td>
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<td>therapeutist/counselor</td>
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<td>Other (__________________________________________)</td>
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10. **Before you were 18**, were you ever forced or coerced to perform sexual acts for money?

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<th>No</th>
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With how many different people did this happen?

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<th>What was their relationship to you? (Check all that apply)</th>
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<td>therapeutist/counselor</td>
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<td>Other (__________________________________________)</td>
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</table>
Your age the first time it happened: 

Your age the last time it happened: 

How many times did it happen: 

How upsetting was it when it happened: (0 = not at all upsetting, 3 = very upsetting) 

How upsetting is the memory of it now: 

Before you were 18, did anyone 5 or more years older than you ever touch your genitals, buttocks, or breasts in a sexual way or have you touch them in a sexual way? 

No 

Yes 

Did any of these incidents include oral, anal, or vaginal intercourse, or the insertion of a finger or an object into your anus or vagina? 

No 

Yes 

Did it happen with a female? 

No 

Yes 

Did it happen with a male? 

No 

Yes 

Was physical force used? 

No 

Yes 

Were threats used? 

No 

Yes 

With how many different people 5 or more years older than you did this happen? 

What was their relationship to you? (Check all that apply) 

Brother/Sister 

Stepfather/Stepmother 

Grandparent/Stepgrandparent 

Friend or Peer 

Other family member 

Professional 

Other ( ) 

Before you were 18, did anyone less than 5 or years older than you use force or threaten to use force to touch your genitals, buttocks, or breasts in a sexual way, or have you touch them sexually? 

No 

Yes 

Did any of these incidents include oral, anal, or vaginal intercourse, or the insertion of a finger or an object into your anus or vagina? 

No 

Yes 

Did it happen with a female? 

No 

Yes 

Did it happen with a male? 

No 

Yes 

Was physical force used? 

No 

Yes 

Were threats used? 

No 

Yes 

With how many different people less than 5 or years older than you did this happen? 

What was their relationship to you? (Check all that apply) 

Brother/Sister 

Stepfather/Stepmother 

Grandparent/Stepgrandparent 

Friend or Peer 

Other family member 

Professional 

Other ( )
13. **Before you were 13**, were there ever times when you were tortured, repeatedly hurt, or forced to do something sexual during some sort of meeting, ritual, cult gathering, or religious activity?  

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14. Were you ever forced to watch this happen to somebody else?  

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If you answered NO to questions 5 through 14, stop here. If you answered YES to any question between 5 and 14, please answer the following questions:

15. Was there ever a time when you couldn't recall or weren't aware that **part** of the sexual abuse had happened?  

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16. If yes, what circumstances prompted you to recall the abuse?  

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<td><strong>Someone revealed their own abuse by the same abuser</strong></td>
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<td><strong>TV shows, books, or movies</strong></td>
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17. Was there ever a time when you couldn't recall or weren't aware that **any** of the sexual abuse had happened?  

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18. If yes, what circumstances prompted you to recall the abuse?  

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<td><strong>Someone revealed their own abuse by the same abuser</strong></td>
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APPENDIX C

DES
Eve Bernstein Carlson, Ph. D. Frank W. Pukin, M. D.

DIRECTIONS
This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

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1. Some people have the experience of driving or riding in a car or bus or subway and suddenly realizing that they don’t remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

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2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

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3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

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4. Some people have the experience of finding themselves dressed in clothes that they don’t remember putting on. Circle a number to show what percentage of the time this happens to you.

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5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

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6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

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7. Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

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8. Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

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9. Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

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10. Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

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11. Some people have the experience of looking in a mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

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12. Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

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13. Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

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14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event. Circle a number to show what percentage of the time this happens to you.

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15. Some people have the experience of not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

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16. Some people have the experience of being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

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17. Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

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18. Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

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19. Some people find that they sometimes are able to ignore pain. Circle a number to show what percentage of the time this happens to you.

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20. Some people find that that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

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21. Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

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22. Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

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23. Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

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24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

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25. Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

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<thead>
<tr>
<th>Percentage</th>
<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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</table>

26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

<table>
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<tr>
<th>Percentage</th>
<th>0</th>
<th>10</th>
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27. Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

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<tr>
<th>Percentage</th>
<th>0</th>
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28. Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

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<th>Percentage</th>
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APPENDIX D

TAS-20

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you STRONGLY DISAGREE
Circle 2 if you MODERATELY DISAGREE
Circle 3 if you NEITHER DISAGREE NOR AGREE
Circle 4 if you MODERATELY AGREE
Circle 5 if you STRONGLY AGREE

1. I am often confused about what emotion I am feeling.  
   1 2 3 4 5

2. It is difficult for me to find the right words for my feelings.  
   1 2 3 4 5

3. I have physical sensations that even doctors don't understand.  
   1 2 3 4 5

4. I am able to describe my feelings easily.  
   1 2 3 4 5

5. I prefer to analyze problems rather than just describe them.  
   1 2 3 4 5

6. When I am upset, I don't know if I am sad, frightened, or angry.  
   1 2 3 4 5

7. I am often puzzled by sensations in my body.  
   1 2 3 4 5

8. I prefer to just let things happen rather than to understand why they turned out that way.  
   1 2 3 4 5

9. I have feelings that I can't quite identify.  
   1 2 3 4 5

10. Being in touch with emotions is essential.  
    1 2 3 4 5

* (Taylor, Boggy & Parker, 1992)
11. I find it hard to describe how I feel about people.

12. People tell me to describe my feelings more.

13. I don't know what's going on inside me.

14. I often don't know why I am angry.

15. I prefer talking to people about their daily activities rather than their feelings.

16. I prefer to watch "light" entertainment shows rather than psychological dramas.

17. It is difficult for me to reveal my innermost feelings, even to close friends.

18. I can feel close to someone, even in moments of silence.

19. I find examination of my feelings useful in solving personal problems.

20. Looking for hidden meanings in movies or plays distracts from their enjoyment.
This questionnaire refers to your alcohol use habits.

**INSTRUCTIONS:**
- For each statement choose the corresponding number you think most accurately answers the following question.
- Choose only one response for each question.
- Please be sure to fill out the boxes in the lower right corner regarding your sex and weight.

1. Think of the occasion you drank the MOST this PAST MONTH. How much did you drink?
   - 0 drinks
   - 1-2 drinks
   - 3-6 drinks
   - More than 6 drinks

2. On a given WEEKEND EVENING, how much alcohol do you typically drink? Estimate for over the PAST MONTH.
   - 0 drinks
   - 1-2 drinks
   - 3-4 drinks
   - 5-6 drinks
   - More than 6 drinks

3. Think of the occasion you drank the MOST this PAST MONTH. How many HOURS did you spend drinking on that occasion?
   - Less than 1 hr.
   - About 1 hr.
   - About 2 hrs.
   - About 3 hrs.
   - 7 or more hrs.

4. On a given WEEKEND EVENING, how many HOURS did you spend drinking? Estimate for over the PAST MONTH.
   - Less than 1 hr.
   - About 1 hr.
   - About 2 hrs.
   - About 3 hrs.
   - 7 or more hrs.

5. How often in the PAST MONTH did you drink alcohol?
   - I do not drink at all
   - About once a month
   - Two or three times a month
   - Once or twice a week
   - Three or four times a week
   - Nearly every day
   - Once a day or more

6. During the PAST SIX MONTHS how often have you used marijuana or hashish?
   - I have not used the substance.
   - Less than once a month
   - About once a month
   - Two or three times a month
   - Once or twice a week
   - Three or four times a week
   - Everyday or nearly everyday

7. During the PAST SIX MONTHS how often have you used cocaine or crack?
   - I have not used the substance.
   - Less than once a month
   - About once a month
   - Two or three times a month
   - Once or twice a week
   - Three or four times a week
   - Everyday or nearly everyday

8. During the PAST SIX MONTHS how often have you used LSD?
   - I have not used the substance.
   - Less than once a month
   - About once a month
   - Two or three times a month
   - Once or twice a week
   - Three or four times a week
   - Everyday or nearly everyday

9. During the PAST SIX MONTHS how often have you used ecstasy?
   - I have not used the substance.
   - Less than once a month
   - About once a month
   - Two or three times a month
   - Once or twice a week
   - Three or four times a week
   - Everyday or nearly everyday

10. During the PAST SIX MONTHS how often have you used any other drugs?
    - I have not used the substance.
    - Less than once a month
    - About once a month
    - Two or three times a month
    - Once or twice a week
    - Three or four times a week
    - Everyday or nearly everyday
This questionnaire refers to your residence and your daily drinking habits.

**INSTRUCTIONS:**

- For each day of the week fill in both the number of drinks consumed and the number of hours you typically drink.
- Please be sure to fill out the boxes regarding your gender, weight, and height.

**QUESTION #1:**

For the PAST MONTH, please fill in a number for each day of the week indicating the TYPICAL NUMBER OF DRINKS you usually consume on that day, and the TYPICAL NUMBER OF HOURS you usually drink on that day.

<table>
<thead>
<tr>
<th>MONDAY</th>
<th>TUESDAY</th>
<th>WED.</th>
<th>THURSDAY</th>
<th>FRIDAY</th>
<th>SATURDAY</th>
<th>SUNDAY</th>
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<th>Weight</th>
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APPENDIX F

UCLA-LS (Version 3)

Instructions: The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by writing a number in the space provided. Here is an example:

How often do you feel happy?

If you never felt happy, you would respond "1" (never); if you always feel happy, you would respond "4" (always).

NEVER RARELY SOMETIMES ALWAYS
1 2 3 4

1. How often do you feel that you are "in tune" with the people around you? __________
2. How often do you feel that you lack companionship? __________
3. How often do you feel that there is no one you can turn to? __________
4. How often do you feel alone? __________
5. How often do you feel part of a group of friends? __________
6. How often do you feel that you have a lot in common with the people around you? __________
7. How often do you feel that you are no longer close to anyone? __________
8. How often do you feel that your interests and ideas are not shared by those around you? __________
9. How often do you feel outgoing and friendly? __________
10. How often do you feel close to people? __________
11. How often do you feel left out? __________
12. How often do you feel that your relationships with others are not meaningful? __________
13. How often do you feel that no one really knows you well? __________
14. How often do you feel isolated from others? __________
15. How often do you feel you can find companionship when you want it? __________
16. How often do you feel that there are people who really understand you? __________
17. How often do you feel shy? __________
18. How often do you feel that people are around you but not with you? __________
19. How often do you feel that there are people you can talk to? __________
20. How often do you feel that there are people you can turn to? __________
APPENDIX G

SEXYAL EXPERIENCES SURVEY

Please circle the correct response.

SINCE THE FIRST SESSION OF THIS STUDY, HAVE YOU:

1. Had sexual intercourse with a man [woman] when you both wanted to? Yes No

2. Had a man [woman] misinterpret the level of sexual intimacy you desired? Yes No

3. Been in a situation where a man [woman] became so sexually aroused that you felt it was useless to stop him [her] even though you did not want to have sexual intercourse? Yes No

4. Had sexual intercourse with a man [woman] even though you didn’t really want to because he [she] threatened to end your relationship otherwise? Yes No

5. Had sexual intercourse with a man [woman] when you didn’t really want to because you felt pressured by his [her] continual arguments? Yes No

6. Found out that a man [woman] had obtained sexual intercourse with you by saying things he [she] didn’t really mean? Yes No

7. Been in a situation where a man [woman] used some degree of physical force (twisting your arm, holding you down, etc.) to try to make you engage in kissing or petting when you didn’t want to? Yes No

8. Been in a situation where a man [woman] tried to get sexual intercourse with you when you didn’t want to by threatening to use physical force (twisting your arm, holding you down, etc.) if you didn’t cooperate, but for various reasons sexual intercourse did not occur? Yes No

9. Been in a situation where a man [woman] used some degree of physical force (twisting your arm, holding you down, etc.) to try to get you to have sexual intercourse with him [her] when you didn’t want to, but for various reasons sexual intercourse did not occur? Yes No

10. Had sexual intercourse with man [woman] when you didn’t want to because he [she] threatened to use physical force (twisting your arm, holding you down, etc.) when you didn’t cooperate? Yes No

11. Had sexual intercourse with a man [woman] when you didn’t want to because he [she] used some degree of physical force (twisting your arm, holding you down, etc.)? Yes No

12. Been in a situation where a man [woman] obtained sexual acts with you such as anal or oral intercourse when you didn’t want to by using threats or physical force (twisting your arm, holding you down, etc.)? Yes No

13. Been raped? Yes No

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APPENDIX H

LEVEL OF DISTRESS

Using the following scale, please indicate your current level of distress after completing these questionnaires:

not at all  moderately distressed  extremely distressed

1---------------------2---------------------3---------------------4---------------------5
APPENDIX I

Consent Form

Principal Investigator:
Linda Frey, M.A.
Clinical Psychology Trainee
University of Montana
Missoula, MT 59812
(406) 243-2614

Research Assistants:
Ellen Crouse, Clinical Psychology Trainee
Alison Cobb, Clinical Psychology Trainee

Faculty Advisor:
Jennifer Waltz, Ph.D.
Clinical Psychologist
Department of Psychology
University of Montana
Missoula, MT 59812
(406) 243-5750

Paige Ripley
Jenelle Johnson
Elizabeth Still

Purpose
The purpose of this research study is to examine factors that may increase risk for sexual victimization in college women.

Procedures
This study involves coming in twice to complete questionnaires, once within the first four weeks and once in the last two weeks of the semester. At the first meeting, which will last approximately 90 minutes, you will be asked to complete a number of questionnaires in private. These questionnaires will ask about your social network, alcohol usage, emotions, current experiences, and past sexual experiences you may have had. You will receive 3 experimental credits for participating in the first session. Please note that you will receive 3 credits for session 1 even if you choose to withdraw from the study or not answer any questions during this meeting.

The second meeting will be held nine weeks later. It will last up to 90 minutes and questionnaires will cover the same type of information as session 1. You will receive the other 3 experimental credits after completion of the second session. You will still receive your credits if you choose to withdraw from the study at any time during the second meeting.

This study is completely voluntary and you are free not to answer any questions you choose not to answer, or to withdraw from participating at any time. The researcher will answer any questions you might have during the study, or you are also free to call at a later time to discuss any concerns.

Risks, Stresses, and Discomforts
It is expected that the questionnaires will be stressful for some people. Some people may experience increased emotional discomfort as they answer questions concerning past difficult events in their life. If you do feel stressed by the procedures, please let the experimenter know how you are feeling. She will talk with you about your feelings in private, and will provide you with resources available to assist you in coping. This study is not specifically designed to provide benefits directly to you; however, some people may find it helpful or informative to respond to the questions presented in the various questionnaires.
Confidentiality

All information you provide will be kept strictly confidential. A code number will be assigned to your data, which will be entered into a computer. Your name will not be used. Your data will be stored in a locked filing cabinet and only the research staff will have access to it. After session 2 data has been collected, all records connecting your name and your data will be destroyed.

There are a few circumstances in which we are ethically and legally bound to break our agreement of confidentiality. We are legally obligated to break confidentiality in certain situations involving potential harm to you or someone else, such as suicide, homicide, child or dependent person abuse. If you provide information in which you communicate substantial intent to physically injure another person or yourself, the researcher will consult with Dr. Jennifer Waltz, clinical psychologist and faculty member. As deemed necessary and appropriate, the researcher will then make efforts to inform that other person and the appropriate authorities of your intent. Additionally, if we receive a court order which requires that we release records about you, we will comply with this order. We will attempt to inform you if any of these situations arise.

Compensation for Injury

The following liability statement is required in all University of Montana consent forms:

"In the event that you are injured as a result of this research, you should individually seek appropriate medical treatment. If the injury is caused by the negligence of the university or any of its employees, you may be entitled to reimbursement or compensation pursuant to the Comprehensive State Insurance Plan established by the Department of Administration under the authority of M.C.A., Title 2, Chapter 9. In the event of a claim for such injury, further information may be obtained from the university's claims representative or University Legal Counsel."

Statement of Consent

I have read the above description of this research study. I have been informed of the risks and benefits involved, and all my questions have been answered to my satisfaction. Furthermore, I have been assured that any future questions I may have will also be answered by a member of the research team (Linda Frey: 243-2614). I voluntarily agree to take part in this study. I understand I will receive a copy of this consent form.

________________________________________
Printed name of research participant

________________________________________
Signature of research participant Date

________________________________________
Signature of researcher Date

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REFERRALS

24-HOUR CRISIS SERVICES:
   U of M Student Assault Recovery Services — 243-6559
   Mental Health Center — 728-6817
   YWCA Crisis Line — 542-1944
   St. Patrick Hospital Emergency Room — 329-5635

COUNSELING SERVICES:
   U of M Counseling and Psychological Services — 243-4711
   U of M Clinical Psychology Center — 243-4523
   YWCA Sexual Assault Services — 543-6691
APPENDIX K

ABOUT THIS STUDY

People who have had previous sexual victimization appear to be at an increased risk for being victimized again (revictimized). While the perpetrator is ultimately the one responsible for any act of sexual aggression, there may be certain characteristics within women who have been victimized previously that place them at a statistically greater risk for being victimized again. This study looked at four factors: feeling numb, having difficulty recognizing and expressing feelings, feeling lonely or with a limited social network, and using alcohol.

These four factors can be associated with a history of sexual victimization and may contribute to heightened risk. Feeling numb can impair a woman's recognition of cues in the environment that may help to signal a risky situation. Having difficulty recognizing and expressing feelings may hinder the ability to interpret some sense of uneasiness in a risky situation; it may also hamper a woman's ability to communicate her wishes or intentions with another person. Feeling lonely or with a limited social network may increase a woman's vulnerability to perpetrators who are seeking out vulnerable individuals. Finally, using alcohol can impair decision-making as well as compromise motor functioning, both circumstances that may decrease a woman's ability to defend herself.

It is very important to recognize that although this study is examining factors that may increase a woman's risk, the responsibility for sexual assault lies solely with the perpetrator. If you have had this kind of experience it is important to understand that it was not your fault. In addition, it is often valuable to get help in dealing with it.

The purpose of the study was to attempt to determine if any of the four factors are related to a statistically heightened risk for sexual revictimization. If you have any questions regarding this study, you can discuss them with the researcher at this time or leave a message for the researcher, Linda Frey, at 243-2614 and she will return your call. In addition, you may also contact the faculty advisor on this project: Dr. Jennifer Waltz at 243-5750.