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# Child Abuse & Neglect



## Emotion dysregulation and risky sexual behavior in revictimization

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### ABSTRACT

**Objective:** The current study examined emotion dysregulation as a mechanism underlying risky sexual behavior and sexual revictimization among adult victims of child sexual abuse (CSA) and child physical abuse (CPA).

**Methods:** Participants were 752 college women. Victimization history, emotion dysregulation, and risky sexual behavior were assessed with anonymous, self-report surveys utilizing a cross-sectional design.

**Results:** Approximately 6.3% of participants reported CSA, 25.5% reported CPA, and 17.8% reported rape during adolescence or adulthood. CSA and CPA were associated with increased risk for adolescent/adult rape; 29.8% of CSA victims and 24.3% of CPA victims were revictimized. Path analytic models tested hypothesized relationships among child abuse, emotion dysregulation, adolescent/adult rape and three forms of risky sexual behavior (e.g., failure to use condoms, contraception, or having sex with someone under the influence of alcohol/drugs), including frequency of risky sexual behavior with a regular dating partner, with a stranger, and lifetime number of intercourse partners. Emotion dysregulation mediated revictimization for both CSA and CPA. Emotion dysregulation also predicted lifetime number of sexual partners and frequency of risky sex with a stranger, but not frequency of risky sex with a regular dating partner.

**Conclusions:** Findings suggest that emotion dysregulation is a distal predictor, and risky sex, particularly with lesser known partners, is a proximal predictor of sexual revictimization. Because emotion dysregulation also maintained a significant direct path to revictimization, risky sexual behavior appears to be one of several proximal risk factors for revictimization.

**Practice implications:** Findings confirm that emotion dysregulation is a critical pathway to more proximal risk factors such as risky sexual behavior, and suggest that clinical interventions aimed at improving emotion dysregulation may help reduce risky sexual behavior and risk for revictimization.

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### Introduction

Child sexual abuse (CSA) victims are between 2 and 11 times more likely to be raped in adulthood, with risk increasing exponentially with severity of CSA (Fergusson, Horwood, & Lynskey, 1997; Wyatt, Gutherie, & Notgrass, 1992). In a review of the then nascent literature, Messman and Long (1996) noted that few empirical studies were designed to examine the issue of revictimization. Since then, studies designed specifically to examine this phenomenon provide evidence of revictimization among college students (Messman-Moore & Long, 2000), community women (Kimerling, Alvarez, Pavao, Kaminski, &

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Baumrind, 2007), inpatients (Cloitre, Tardiff, Marzuk, Leon, & Portera, 1996), female inmates (Walsh, DiLillo, & Scalora, in press), and military veterans (Schultz, Bell, Naugle, & Polusny, 2006). Revictimization also has been documented among ethnically diverse populations, including Latina, African American, and Asian American women (Urquiza & Goodlin-Jones, 1994), bisexual women and gay men (Heidt, Marx, & Gold, 2005), and low-income, urban women (Siegel & Williams, 2003). Revictimization appears to compound the psychological impact of prior victimization, and is associated with increased distress among victims, including higher levels of anxiety, lifetime and current depression, lifetime and current PTSD, dissociation, binge drinking and past month drug use (Casey & Nurius, 2005; Cloitre, Scarvalone, & Difede, 1997; Kimerling et al., 2007). The widespread psychological impact of revictimization raises the critical question of why some CSA survivors experience additional victimizations while others do not. Identifying factors that distinguish these groups will inform interventions designed to prevent revictimization and the psychological burden associated with it.

### *Revictimization models and prevention*

Most models of revictimization focus on how traumatic sequelae associated with CSA influence psychological, cognitive, behavioral, and interpersonal functioning, which subsequently increase risk for revictimization (Cloitre & Rosenberg, 2006; Marx, Heidt, & Gold, 2005; Messman-Moore & Long, 2003). Numerous forms of CSA-related symptomatology or impaired functioning have been linked to revictimization, including posttraumatic symptomatology (Risser, Hetzel-Riggin, Thomsen, & McCanne, 2006), dissociation (Noll, Horowitz, Bonano, Trickett, & Putnam, 2003), risk perception (Messman-Moore & Brown, 2006), alcohol and substance abuse (Casey & Nurius, 2005), interpersonal difficulties (Rich, Gidycz, Warkentin, Loh, & Weiland, 2005), and risky sexual behavior (Orcutt, Cooper, & Garcia, 2005).

Although this work has been useful in identifying factors that may mediate the association between CSA and adult revictimization, this knowledge has not necessarily translated into effective prevention programming. Although some suggest that programming may be helpful in reducing sexual assault rates, these interventions have shown relatively little effectiveness for women who already have been sexually victimized (Gidycz et al., 2001; Marx, Calhoun, Wilson, & Meyerson, 2001). A program by Gidycz et al. (2001) reduced revictimization during a 6-month follow-up for women with moderate (as opposed to severe) sexual victimization, and Marx et al. (2001) reduced risk for verbally coercive revictimization (versus rape) in a 2-month follow-up period. No studies of revictimization prevention have focused on addressing traumatic sequelae (e.g., PTSD symptoms, alcohol use) to reduce risk, although in a pilot treatment study of women who were recently sexually victimized, those receiving group therapy were less likely to report sexual revictimization post-treatment (Classen, Koopman, Nevill-Manning, & Spiegel, 2001). Given the modest success of current interventions, it seems prudent to continue to identify risk factors that could be addressed.

One potential explanation for the limited success in revictimization prevention is the failure to adequately specify pathways leading from early to later victimization. Empirical studies demonstrate that multiple mediating processes underlie revictimization, yet it is not feasible to incorporate all risk factors into revictimization interventions. Moreover, interventions may be more efficient and effective if they incorporate mechanisms that underlie multiple empirically identified mediators of revictimization. Most revictimization risk factors fall within one of three domains: PTSD, interpersonal relatedness difficulties, and affect dysregulation (Cloitre & Rosenberg, 2006). In fact, the majority of identified risk factors (i.e., dissociation, substance use, risky sexual behavior, risk perception) may be linked to failure to self-regulate negative affective states, which is particularly likely to occur among CSA victims (Cloitre & Rosenberg, 2006; Marx et al., 2005). If emotion dysregulation leads to behaviors that increase risk for revictimization, then an effective yet parsimonious intervention may be developed focusing on this difficulty. Thus, secondary preventive interventions with high-risk women (i.e., targeting women high in emotion dysregulation) may be a worthwhile strategy. However, although intervention focused on emotion dysregulation makes intuitive sense, it is important to empirically establish its relevance in the process of revictimization. If this can be accomplished, emotion dysregulation would be a promising target for intervention because it appears to precede numerous proximal risk factors, setting the stage for increased vulnerability and revictimization.

### *Emotion dysregulation*

Childhood maltreatment is known to have a detrimental impact on development of emotion regulation capacity, and deficits in emotion regulation strategies increase vulnerability for psychological disorders. Emotion dysregulation typically begins in childhood (e.g., Shields & Cicchetti, 1998) and often persists into adolescence and adulthood (Kilpatrick et al., 2003). Some conceptualizations of emotion regulation emphasize the control of emotional experience and expression (especially of negative emotional states), while others emphasize that adaptive emotion regulation involves awareness and understanding of emotions (Thompson & Calkins, 1996). Hayes, Wilson, Gifford, Follette, and Strosahl (1996) posit that efforts to avoid (and control) internal experiences, including emotional experience—a phenomenon called experiential avoidance—is inherently harmful to psychological functioning and may underlie many psychological disorders. There is growing consensus that adaptive emotion regulation involves the flexible use of skills to modulate emotional experience (e.g., altering the intensity or duration of an emotion) rather than eliminating certain (negative) emotions. A recent comprehensive model proposed by Gratz and Roemer (2004) integrated numerous aspects of emotion regulation including emotional awareness, understanding and acceptance; ability to control impulsive behaviors when experiencing negative emotions; and ability to use emotion regulation strategies flexibly to modulate emotional responses to meet individual goals and situational demands.

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