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Research Article

Revictimization and the Specificity Hypothesis- Do Different Subtypes of Interpersonal Violence Predict each Other?

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Abstract

Background: Revictimization refers to the finding that victims of child abuse have an increased risk of experiencing violence as adolescents and adults. To date, revictimization has been well documented for sexual violence. Recent findings show that the same phenomenon occurs for physical and emotional types of violence and indicate specificity in the relationship. In particular, childhood sexual abuse predicts sexual violence in adulthood and childhood physical abuse predicts future physical victimization. Although emotional violence is among the most harmful types of maltreatment, emotional revictimization has not yet been systematically documented. The aim of this study was to investigate how the three different types of childhood abuse (sexual, physical, and emotional) were related to the three different types of adult victimization (sexual, physical, and emotional).

Methods: In an online survey of 135 adult women with high levels of victimization, sexual, physical and emotional experiences of violence were assessed separately for childhood and adulthood.

Results: Linear regressions indicated specific relationships between childhood sexual and physical abuse and sexual violence in adulthood (standardized beta coefficients .33*** and .21*), while childhood physical abuse predicts physical violence in adulthood (standardized beta coefficient .44***).

Emotional violence experiences in adulthood were predicted by childhood sexual and emotional abuse (standardized beta coefficients .20*** and .08*).

Conclusions: The findings partly support the specificity hypothesis of revictimization and have significant implications for practice, particularly for the development of more effective approaches to preventing repeated violence.

Keywords: Sexual; Physical and Emotional Violence; Child Abuse; Revictimization; Specificity Hypothesis

1. Introduction

Victims of childhood abuse have an increased risk of becoming victims of violence again in adolescence and adulthood [1]. This phenomenon is called revictimization and has been recognized as a phenomenon with considerable public-health impact [2]. Two out of three individuals who have experienced abuse in childhood fall victim to sexual abuse again later in life [3]. Women who have experienced physical or sexual abuse in childhood are 3.5 times more likely to become victims of domestic violence [4]. To date, most studies have focused on sexual revictimization [5]. That is, the relationship between child sexual abuse and sexual victimization in adulthood. However, recent research has indicated that revictimization phenomena are not restricted to the repetition of sexual violence across developmental stages, as childhood physical abuse is also associated with adult sexual victimization [6, 7]. Further, research into inter-partner violence revealed that experiences of various types of violence in childhood predict subsequent domestic violence [4]. Unfortunately, these studies fall short of analyzing the specificity of the relationship between different types of abuse and adult victimization, due to their use of globalscores on abuse.

This is especially important given that recent research suggests that there is not only a cumulative effect of childhood abuse, but that the type of violence experienced in childhood is related to the type of violence experienced later in adulthood [8, 9]. For example, a recent study showed that experiences of childhood sexual abuse uniquely predicted adult sexual abuse [9] and that, similarly, childhood physical abuse predicted adult physical abuse. These results can be interpreted in terms of a "specificity hypothesis" which states that the types of violence experienced in childhood (sexual and physical) are specifically related to the types of violence experienced in adulthood (sexual and physical). This hypothesis has implications for the study of the mechanisms of revictimization, since specific relationships should be carried by specific processes of revictimization.

Thus far, support for the specificity hypothesis is still limited and restricted to physical and sexual types of violence. Although emotional maltreatment belongs to the most harmful type of abuse and is related to negative outcomes, including psychopathology [10], the contribution of emotional violence to revictimization has not yet been investigated. In previous studies, emotional abuse in childhood has been considered only in combination with other types of violence; experiences of emotional violence in adulthood have not yet been studied in the context of revictimization [9]. However, research investigating the consequences of emotional abuse [10-12], indicates that specific patterns of behavior and experience emerge in the wake of childhood emotional abuse, which in turn represent a risk factor for

the experience of adult emotional abuse. Emotional violence in childhood is associated with low self-esteem [11] and lack of social skills [12]. Low self-esteem, in combination with a lack of social skills, represents a predictor for later emotional victimization [13]. In particular, lack of social skills contributes to the exclusion from "normal groups" [14] which has been interpreted as emotional violence. In addition, individuals with low self-esteem and social isolation are often regarded as "easy victims" of bullying or emotional violence in partnerships.

There is reason to assume that revictimization spans all types of violence and abuse, including emotional abuse. In addition, some findings suggest different revictimization processes and support the specificity hypothesis of revictimization. So far, studies that systematically record all three types of violence experiences in childhood, adolescence and adulthood are still lacking. The present study sought to address this gap in the literature. In particular, we aimed to determine the extent to which different types of childhood abuse (sexual, emotional and physical) are related to different types of adult violence (sexual, emotional and physical). For this purpose, we studied a sample of adult women with a wide range of victimization experiences and recorded retrospective reports on childhood as well as adulthood victimization. We considered a web-based survey as particularly suitable for this study since it allowed us to include highly affected individuals in our sample through the use of announcements in specific self-help groups and forums. In addition, web-based surveys allowed for full anonymity for respondents, which may have increased the participants' willingness to report sensitive and shameful content.

2. Method

2.1 Procedure

The data for this study was collected in an online survey created with the Unipark software (Unipark, E.F.S. Survey, version 7). The aim was to recruit a sample with a large variance on the study variables, including maltreatment and revictimization, without focusing primarily on a clinical population. For this purpose, the link for participation was published in Facebook and in self-help groups on the Internet which are addressing the topic of traumatic life experiences. On the first page of the survey, the participants were informed about the contents and risks of the study, about the voluntary and anonymous nature of the survey and the possibility to desist at any time without penalty. This was followed by a declaration of consent to participate in the study. First, demographic data (age, gender, education) were collected. Afterwards, the experience of different types of violence in childhood was investigated. In order to avoid closure effects, the pursue of various types of violence in adolescence and adulthood was only then examined. Subsequently, psychopathology was recorded. The programming of the survey was such that each question required a response by the participant. The average time taken to complete the survey was 23 minutes. The ethical considerations of this study were reviewed and approved by the Ethics Committee of the Department of Psychology at Bielefeld University. This study was part of a larger survey, that also included additional psychological variables that are not part of this analysis.

2.2 Participants

In total, N= 1062 participants commenced the study and of those n= 155 finished it, leaving the

completion rate at 14.6%. Most drop-outs took place on the start page (n=789, 74.29%). Under 3% (n= 26) of drop-outs occurred at the declaration of consent and n = 20, 1.88 % drop-outs occurred during the indication of socio-demographic data. For all other questions, there was no noticeably higher number of drop-outs. The study was active for a total of 182 days. The average number of participants per day was 7.08. Of the 155 participants who completed the study, only female and adult participants were considered. Therefore, eight underage participants and twelve men were excluded. The final sample thus consisted of N=135 participants aged 19 to 67 years (M = 33.4; SD = 11.12). They had an average of 14 years (SD = 3.27) of formal education (primary school, secondary school, university).

2.3 Measures

2.3.1 Child abuse experiences: The Childhood Trauma Questionnaire [15, 16] is a self-assessment tool for the retrospective assessment of abuse and neglect in childhood. With 28 items, the questionnaire covers the subscales of sexual abuse, emotional abuse, physical abuse, emotional neglect andphysical neglect. The items are to be answered on a five-point Likert scale. The decision on the existence of the different types of abuse was made on the basis of the cut-off values for the summed item scores of Walker et al. [17]. The CTQ showed good internal consistency for all scales in validation studies [18] besides the scale of physical neglect. Due to the low internal consistency of this scale and its high intercorrelation with the other scales [18] it was not included for analysis in the present study.

2.3.2 Sexual victimization in adolescence and adulthood: The Potsdam scales for recording sexual aggression and victimization [19] are a self-report instrument for the assessment of sexual aggression and victimization after the age of 14. For the purpose of this study only the sexual victimization subscale was used. The Potsdam scales record sexual victimization with sixteen items each using a four-point scale. These include the type of pre-relationship between offender and victim ((former) partners, acquaintances or strangers). In order to harmonize this instrument with the other assessments, the category "colleagues or supervisors at the workplace" were added here. Three different strategies for exerting pressure were asked (use/threat of physical violence, exploitation of inability to resist, and verbal pressure). A more precise differentiation of forced sexual acts (sexual contact, attempted sexual intercourse, sexual intercourse and other sexual acts, e.g., oral sex) is mentioned in the explanatory text. This more precise differentiation is removed from the item query, as it is not relevant for the purpose of this study. Persons are considered victimized if they have been exposed to sexual aggression on at least one occasion. As this is a newly developed instrument, no validity or reliability criteria were available. For the present evaluation, the total scores of all items assessing victimization represented the experience of sexual violence in adolescence and adulthood.

2.3.3 Physical and emotional victimization in adolescence and adulthood: A recently created screening instrument was used to record and quantify the experience of physical and emotional violence. It was developed for one of the main German epidemiological studies on health, the "Study on Adult Health in Germany" (DEGS1) of the Robert Koch Institute [20]. It explores whether there have been physical or emotional experiences of violence, both from the victim's and the perpetrator's perspective. Thepreliminary relationship between perpetrator and

victim is also recorded ((former) partners, acquaintances, work colleagues/supervisors at the workplace or strangers). In order to avoid confusion with experiences of intrafamily childhood violence, the category of "one person fromthe family" was omitted. For the same reason, participants were instructed to select the items only if the experience had taken place at or after the age of 14. An additional question on the burden of the respective experience of violence was removed as it was not relevant for the purpose of this study. In total the instrument consisted of 16 items, which were answered on a four-point Likert scale regarding the frequency of occurrence. As this study only considered the victim`s perspective, eight items about the perpetrator`s perspective were left out. For the present evaluation, the total scores of all items concerning victimization represent the experience of physical or emotional violence in adolescence or adulthood.

2.3.4 PTSD symptoms: The Primary Care PTSD Screen [21] is a screening instrument for the detection of post-traumatic stress disorder (PTSD). The scale consists of four items in dichotomous response format (Yes/No). It asks whether a person has experienced four symptoms typical of PTSD in the last month: Re-experience, numbness, avoidance, and hyperarousal. The PC-PTSD has optimum efficiency in terms of the best possible combination of sensitivity and specificity at a cut-off value of three [21]. The cut-off value was only used for descriptive purposes in this study. The summed item scores were used in the evaluation, representing a value for the exposure to symptoms of PTSD. The PC-PTSD has good retest reliability and correlates highly with the standard instrument for the detection of PTSD, the Clinician Administered PTSD Scale [21].

2.3.5 Symptoms of depression: The health questionnaire for patients [22] is a screening instrument used for the detection of a depressive disorder. The self-report questionnaire contains nine items that assess whether typical symptoms of depression (based on the DSM-IV criteria) have occurred in the last two weeks. The items were answered on a four-point scale. The PHQ-9 has previously demonstrated good validity and retest reliability [23]. In addition, good values for sensitivity and specificity were confirmed for the stated cut-off values for the severity of depressive symptoms (Kroenke, Spitzer & Williams, 2001). These cut-off values were only used for descriptive purposes in this study. The summed item scores were used in the evaluation representing a value for the burden of symptoms of depression.

2.4 Statistical analyses

The statistical analyses of the study were carried out with the statistical program IBM SPSS Statistics, version 21. All procedures refer to the significance level $a = .05$. To describe the sample characteristics, the variables of sexual, physical, emotional abuse, emotional neglect in childhood and sexual, physical, and emotional experiences of violence in adulthood were treated as dichotomous variables using the cut-off values described above. They were used as continuous variables in all further analyses. The scales of emotional abuse and emotional neglect were combined due to their high correlation (sum of the scores of the individual scales).The scale of emotional abuse reflected this composite value. In order to test the predictors for the experience of violence in adulthood, linear regressions were calculated. To carry out the regression analyses, the normal distribution of the residuals was checked by visual inspection first. According to the question of what specific contribution different types of childhood

abuse experiences make to the prediction of a subsequent revictimization, all potential predictors were simultaneously included in the regression model. In a first linear regression, the variable sexual experiences of violence in adulthood served as a dependent variable. Independent variables were sexual abuse, emotional abuse, and physical abuse in childhood. In the following two linear regressions, the same independent variables were used. The dependent variables were experiences of physical violence in adulthood and experiences of emotional violence in adulthood.

3. Results

Overall, 83 % of the participants stated that they had experienced violence in adolescence or adulthood, with experiences of emotional violence occurring as the most frequent form in our sample (83%). Eighty-seven percent of the participants were victims of at least one subtype of interpersonal violence in childhood. For 81% of participants, emotional abuse was the most frequent form of violence during childhood. Of the 117 participants who had experienced any form of violence in childhood, 115 re-experienced violence in adulthood and were thus regarded as revictimized. The results of the short screenings suggest an increased psychopathological stress in the examined sample. Seventy-six percent of the participants answered in the affirmative to three out of four questions about post-traumatic symptoms and were thus above the cutoff value, which seems to indicate the possible presence of PTSD [21]. When responding to the PHQ, 83 % of the participants were above the value of 15, which is considered to be indicative of a potential depressive risk; such as a moderate depressive episode. A complete overview of the descriptive statistics can be found in Table 1. A more detailed overview of the frequencies of different types of violence as well as the different perpetrators can be found in Figures 1 and 2.

3.1 Predicting sexual, physical and emotional victimization in adulthood from abuse experiences in childhood

In all regression analyses conducted in this sample, the scatterplot of residuals did not indicate a deviation from the normal distribution. A test of the multicollinearity of the predictors showed that although the predictors correlated with each other, the assumption of multicollinearity was not violated. The regression analyses could therefore be carried out without restriction. The results of the regression analyses for the variables sexual, physical, and emotional experiences of violence in adulthood are shown in Table 2. Significant predictors of sexual violence in adulthood were sexual abuse and physical abuse in childhood. Physical experiences of violence in adulthood were significantly predicted by physical abuse in childhood. Significant predictors for emotional experiences of violence in adulthood were sexual abuse and emotional abuse in childhood.

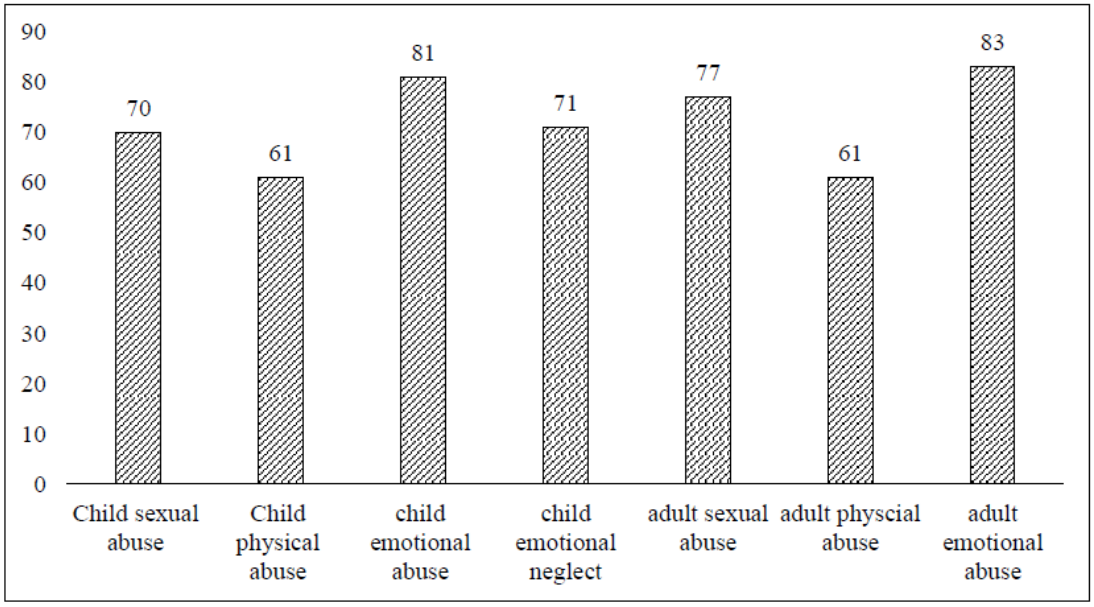

Figure 1: The number of participants (in percent) who achieve the cut-off values of the abuse or neglect criteria in childhood or adulthood.

	M(SD)	***N* (%) above the cutoff value**
Age	33.40 (11.12)	
Formal education	13.66 (3.27)	
Child emotional abuse	17.76 (6.47)	81
Child physical abuse	11.39 (6.30)	61
Child sexual abuse	14.84 (7.72)	70
Child emotional neglect	17.71 (5.93)	71
Child emotional abuse (composite)	35.47 (11.41)	
Adult sexual abuse	5.53 (5.42)	77
Adult physical abuse	2.29 (2.76)	61
Adult emotional abuse	5.65 (4.10)	83
PTSD symptoms	3.10 (1.47)	76
Depression symptoms	14.42 (7.63)	73

Table 1: Descriptives.

	Sexual Victimization[1]		**Physical Vic.**[2]		**Emotional Vic.**[3]	
Predictors	β	r	β	r	β	r
Child sexual abuse	.33 ***	,54 **	.16	.45**	.20***	.44**
Child physical abuse	.21 *	,42 **	.44 ***	.55 **	-.05	.32**
Child emotional abuse	.03	,35 **	.001	.40 **	.08*	.37**

Note. β: standardized beta coefficient; r: 0-order correlation (Sperman).

[1] corrected $R^2 = .27$, $F(3,131) = 17.70$, $p < .001$

[2] corrected $R^2 = .30$, $F(3,131) = 19.97$, $p < .001$

[3] corrected $R^2 = .21$, $F(3,131) = 12.57$, $p < .001$

* p< .05. ** p< .0.1. ***p< .001

Table 2: Predictors of sexual victimization, physical victimization and emotional victimization (Predictors: Experiences of violence in childhood).

4. Discussion

In an online survey with individuals with high rates of experiences of violence we found evidence to support the specificity hypothesis of revictimization. Across developmental stages, specific types of abuse were inter-correlated: childhood sexual abuse predicts adult sexual violence, and childhood physical abuse predicts adult physical violence. The assumption specificity could partly be extended to emotional violations, since and adult emotional violence is predicted by childhood emotional maltreatment, but also by childhood sexual abuse. In terms of sexual and physical revictimization, these results are consistent with the results of studies by Langer and Catani [9] and Blom and colleagues [8], which also provided evidence of the specificity hypothesis. However, other findings argue against differentiation based on the type of violence. Coid and colleagues [4] showed that, although less severe forms of abuse in childhood are associated with similar forms of abuse in adulthood, more severe forms of abuse seemed to lead to a generalization effect. The more severe the childhood sexual or physical abuse was, the more generalized the revictimization experienced in adulthood was for sexual and physical assault. However, in the study by Coid et al [4], an increasing severity of childhood experiences of violence also involved the presence of more subtypes of childhood experiences of violence, which could explain that later experiences of victimization were both sexual and physical.

Contrary to the specificity hypotheses, adult emotional violence was predicted by childhood sexual abuse as well as childhood emotional abuse. Since this is, to the best of our knowledge, the first investigation of emotional violence and revictimization, it is not yet possible to refer to confirmatory or contradictory research results. We speculate that this discrepancy may be explained on the basis of the contribution of maltreatment to attachment. Children form mental representations of themselves in relationships and of others as their relationship partners, based on their previous history with important reference persons [24]. These experiences remain stable individual working models about relationships into adulthood and influence the way children design certain model-consistent interaction dynamics

(Wekerle & Wolfe, 1998). Through childhood experiences of abuse, distorted cognitions about power, control, attachment, trust, and possibly intimacy emerge [25]. These distorted cognitions thus also have an effect in adulthood. In case of childhood physical abuse, such an effect can be seen, for example, in increased attachment anxiety, i.e. the exaggerated fear of being abandoned with a simultaneous strong need for closeness [26]. For individuals with strong attachment anxiety, the personal costs of distancing themselves from their interaction partners in high-risk situations, as well as the costs of offering resistance, are correspondingly higher [26]. It could therefore be assumed that victims of childhood physical abuse are more likely to accept physical violence from their partners in order not to endanger the relationship and the associated closeness.

With regard to childhood emotional abuse, it could be assumed that the children have internalized the derogatory statements about themselves and perceive themselves as "worthless", "stupid", "lazy" or "ugly" [11]. Such self-perception prevents normal interaction with the environment and promotes social withdrawal [11]. As described above, additional social skills are not learned [12], which is often accompanied by exclusion from "normal groups" [14]. This exclusion alone can be an experience of emotional violence in and of itself. Furthermore, such persons are often regarded as "easy victims" of experiences of emotional violence in social groups or in partnerships. Following childhood sexual abuse there may be two paths: on the one hand to sexual revictimization, on the other hand to emotional revictimization. With regard to the connection between childhood sexual abuse and sexual violence in adulthood, it can be assumed that distorted cognitions exist about sexuality, intimacy, and power [25]. If caring and abusive behavior take place simultaneously in families, abuse may even be confused with sexuality and intimacy (Downs, 1993). In the context of emotion regulation, distorted cognitions make dysfunctional sexual behavior (i.e. using sexual activity to meet nonsexual needs e.g., affect regulation, having sex with someone under the influence of alcohol/drug frequency, increased number of sexual partners or sexual intercourse with strangers) more likely [27]. This behavior can, on the one hand, be misinterpreted as consenting to sexual contact, or, on the other hand, it can lead to a person being regarded as an "easy victim" of sexual violence [28].

Another possible impact of childhood sexual abuse, beyond potential dysfunctional sexual behavior, may be shown in internalized feelings of shame. The decisive factor for whether externalization tendencies or internalization tendencies arose could be represented in the processing or explanation at that time by the family or perpetrator of the sexual abuse. An internalization of self-deprecating cognitions can lead to a similar self-perception as described above concerning adult emotional violence and thus lead to a social withdrawal. Social isolationincreases the risk of being seen as an "easy victim" of negative behaviors such as bullying or emotional violence in partnerships. When considering the impact of the findings of the present study, it is critical to considerthe strengths and weaknesses of the study design itself. The strength of this study lies in the systematic recording of all three types of violent experiences (sexual, emotional, and physical) both in childhood and in adulthood. The results therefore represent an extension of the current state of knowledge in the field of revictimization research, which has so far largely

concentrated on sexual and physical abuse in childhood. Only this approach allows statements to be made about specific relationships between certain types of violence in childhood and adulthood and thus provides valuable insights for the development of specially tailored prevention approaches for victims of sexual, physical, or emotional violence. Similarly, the form of the online survey could be considered advantageous as it minimalizes the tendency towards socially desirable answers by the anonymity of this form of survey. In addition, this procedure allows accessing a wide variety of subjects. In contrast to studies recruiting college students or clinical samples only, we have hardly any barrier with regard to study participation other than access to the internet. However, since we refrained to explicitly ask for indicators of diversity such as sexual orientation, disability and migration background, we can not exclude that the sample may be more homogenous than intended.

However, limitations of the present work must also be mentioned: With regard to the recording of physical and emotional violence in adulthood, the newly developed instrument does not yet provide valid cutoff values for frequencies. In accordance with the assessment of sexual violence, a cutoff value of 1 was chosen. However, it can be assumed that the frequencies of emotional violence are distorted. Nor can bullying experiences at school be depicted with the instrument used. Basically, the cross-sectional design used does not permit reliable statements about causal relationships between the recorded variables. Information from longitudinal studies with large, ideally representative samples would certainly be desirable here. In summary, the results of the study provide an important confirmation of the specificity hypothesis and show that the processes underlying the revictimization phenomenon must be viewed in a more differentiated way. Particularly novel and valuable are the findings on emotional violence, which suggest that this form of violence should not be neglected in research and clinical practice. Future studies, ideally with a longitudinal design, should be devoted to the further investigation of these connections in order to be able to make valid statements regarding the consequences of child abuse for the later revictimization of those affected. In spite of the relationships found between the experiences of violence, it is still possible to speculate about the specific mechanisms of action as to why revictimization occurs at all. It would be urgently necessary to examine the underlying mechanisms in order to find out which variables might mediate the relationships identified in the present study. Such knowledge would be indispensable in specifying prevention approaches for the victims of experiences of violence and thus to prevent revictimization.

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