PERITRAUMATIC DISSOCIATION, LACK OF RESOLUTION, AND REVICTIMIZATION IN SURVIVORS OF SEXUAL TRAUMA: AN AVOIDANCE DILEMMA?

A thesis presented to

the faculty of

the College of Arts and Science of Ohio University

In partial fulfillment

of the requirements for the degree

Master of Science

Audrey K. Miller

August 2002
This thesis entitled
PERITRAUMATIC DISSOCIATION, LACK OF RESOLUTION, AND REVICTIMIZATION IN SURVIVORS OF SEXUAL TRAUMA:
AN AVOIDANCE DILEMMA?

BY

AUDREY K. MILLER

has been approved for
the Department of Psychology
and the College of Arts and Sciences of Ohio University by

Christine A. Gidycz
Associate Professor of Psychology

Leslie A. Flemming
Dean, College of Arts and Sciences
Peritraumatic dissociation (i.e., psychologically removing one’s self during or immediately following the events of a trauma) has been demonstrated by past studies to be related to posttraumatic symptoms in various traumatized samples. In the present study, an avoidant response to sexual trauma is investigated in a sample of 144 college women who have adolescent histories of unwanted sexual intercourse. Using a prospective design, both peritraumatic dissociation and peritraumatic distress are found to be predictive of posttraumatic avoidance, dissociation, cognitive discord, and, interestingly, posttraumatic growth. Furthermore, controlling for other peritraumatic and posttraumatic symptoms, posttraumatic cognitive discord is predictive of revictimization (i.e., unwanted intercourse) during a 4.2-month follow-up period.

Approved: Christine A. Gidycz
Associate Professor of Psychology
Acknowledgments

Thank you to my family, who has enriched my past and encourages me into the future.
To my friends, who know just what to say, which music to play, and which recipes to lend. And to dear Ian, who (ever so gently) encourages and inspires me daily as I place my feet along the way.

I am so fortunate to know your minds, and especially, to experience your hearts.

Finally, thank you to Drs. John Garske, Chris Gidycz, and Tim Heckman, my committee, for your insights, to Joanna Pashdag, for a thoughtful dialogue, and to Dr. Bruce Carlson, for the gracious sharing of your expertise.
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of Tables</td>
<td>8</td>
</tr>
<tr>
<td>List of Figures</td>
<td>9</td>
</tr>
<tr>
<td>Overview</td>
<td>10</td>
</tr>
<tr>
<td>The Literature</td>
<td>15</td>
</tr>
<tr>
<td>What Female Sexual Victimization Looks Like: A Contemporary Scope</td>
<td>15</td>
</tr>
<tr>
<td>Risk Factors and Sequelae: Reciprocal Vulnerability</td>
<td>20</td>
</tr>
<tr>
<td>PTSD and Dissociation: A Focus on Avoidant Cognitive Response to Trauma</td>
<td>25</td>
</tr>
<tr>
<td>Peritraumatic Dissociation: A Marker of Avoidant Cognitive Style?</td>
<td>30</td>
</tr>
<tr>
<td>Avoidance as a Conceptual Path to Posttraumatic Symptomatology in</td>
<td>34</td>
</tr>
<tr>
<td>Victims of Sexual Trauma</td>
<td>34</td>
</tr>
<tr>
<td>Trauma and Revictimization</td>
<td>38</td>
</tr>
<tr>
<td>Cognitive Processing Theories of Trauma: How Avoidance May Play into Revictimization</td>
<td>40</td>
</tr>
<tr>
<td>Sociolegal Dissociation: The Prevalence of Unacknowledged Victimization and the Context of Cognitive Avoidance</td>
<td>49</td>
</tr>
<tr>
<td>The Present Study</td>
<td>57</td>
</tr>
<tr>
<td>Hypotheses</td>
<td>61</td>
</tr>
<tr>
<td>Methodology</td>
<td>62</td>
</tr>
</tbody>
</table>
Appendix F: Peritraumatic Dissociative Experiences Questionnaire…………151
Appendix G: Peritraumatic Distress Inventory……………………………...152
Appendix H: Impact of Event Scale-Revised…………………………………153
Appendix I: Dissociative Experiences Scale Revised – Version 2………………155
Appendix J: Posttraumatic Cognitions Inventory………………………………159
Appendix K: Posttraumatic Growth Inventory…………………………………161
Appendix L: Interview Format…………………………………………………..163
Appendix M: Debriefing Forms…………………………………………………164
List of Tables

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participant Demographics</td>
<td>63</td>
</tr>
<tr>
<td>2. History of Highest Level of Sexual Victimization Since the</td>
<td>80</td>
</tr>
<tr>
<td>Age of 14 at Screening</td>
<td></td>
</tr>
<tr>
<td>3. Victims’ Descriptions of Adolescent Sexual Assault Experiences</td>
<td>81</td>
</tr>
<tr>
<td>4. Frequency of Revictimization After 4.2 Months in Eligible Sample</td>
<td>83</td>
</tr>
<tr>
<td>5. Linear Regression Model: Constructs and Measures Utilized</td>
<td>84</td>
</tr>
<tr>
<td>Measures</td>
<td></td>
</tr>
<tr>
<td>7. Pearson Correlations Among Measures</td>
<td>89</td>
</tr>
<tr>
<td>8. Logistic Regression Model: Constructs and Measures Utilized</td>
<td>91</td>
</tr>
</tbody>
</table>
List of Figures

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Study Time Line and Instruments Utilized at Each Phase</td>
<td>76</td>
</tr>
<tr>
<td>2. Linear Regression Model: Relationship Between Peritraumatic Dissociation and Cognitive Outcome Variables</td>
<td>85</td>
</tr>
<tr>
<td>3. Logistic Regression Model: Relationship Between Cognitive Variables and Revictimization</td>
<td>92</td>
</tr>
<tr>
<td>4. Revised Model Supported by Linear and Logistic Regression Analyses</td>
<td>94</td>
</tr>
</tbody>
</table>
Peritraumatic Dissociation, Lack of Resolution, and Revictimization in Survivors of Sexual Trauma: An Avoidance Dilemma?

Overview

Over the past 20 years, sexual assault particularly of women has become well established as endemic in the grain of American culture (Andreoli Mathie & Kahn, 1995; Gidycz, Coble, Latham, & Layman, 1993; Kahn, Andreoli Mathie, & Torgler, 1994; Kilpatrick, Saunders, Veronen, Best, & Von, 1987; Koss, 1988, 1993; Koss, Gidycz, & Wisniewski, 1987; Russell, 1983; Wyatt, 1985). Our understanding of the nature and gravity of the phenomenon has developed along with creative research, and it is more clear than ever that although assaultive behaviors persist, these experiences are yet underrecognized, delegitimized, and unacknowledged by the general public and victims alike (Kahn & Andreoli Mathie, 2000; Koss, 1985, 1988, 1990, 1992, 1996, 1998; Koss et al., 1987; Layman, Gidycz, & Lynn, 1996; Mynatt & Allgeier, 1990; Pitts & Schwartz, 1993; Russell, 1982). While empirical study of the causes, correlates, and consequences of sexual victimization has shed increasing light on various aspects of the problem, a holistic model which integrates differential cognitive responses to sexual trauma into a sociocultural fabric, and, moreover, ties these to future vulnerability and revictimization, is still wanting.

With prevention in mind, studies have looked at risk factors that increase the chances that a woman might be sexually victimized. Among the empirical foci are perpetrator studies (e.g., Cornett & Shuntich, 1991; Layman, 1996; Ouimette & Riggs, 1998; Rapaport & Burkhart, 1984); however, the majority of studies have focused on
women, that is, their demographic, interpersonal, psychological, and behavioral risk factors that may play some role in the complex dynamic of assault (e.g., Acierno, Resnick, Kilpatrick, Saunders, & Best, 1999; Amick & Calhoun, 1987; Bart & O’Brien, 1984; Brener, McMahon, Warren, & Douglas, 1999; Burnam et al., 1988; Fisher, Cullen, & Turner, 2000; Greene & Navarro, 1998; Koss & Dinero, 1989; Merrill et al., 1999; Muehlenhard & Linton, 1987; Murnen, Perot, & Byrne, 1989; Reig, 1999; Sandberg, 1995; Zoucha-Jensen & Coyne, 1993). Despite this extensive body of literature on risk, it is presently emphasized that many of these personal risk factors are also repercussions of victimization, and it may be illusory and dangerous to assume either isolation of variables (Acierno et al., 1999; Hanson, Kilpatrick, Falsetti & Resnick, 1995) or victim fault (Bublick, 1999; Koss & Dinero, 1989) in risk factor studies. This literature might more accurately be conceptualized as a vulnerability literature, given that most of these factors (e.g., depression, fear and anxiety, anger, disrupted social and sexual functioning and satisfaction, PTSD) have been established not only as contributors to, but also as sequelae resulting from, sexual victimization (Atkeson, Calhoun, Resick, & Ellis, 1982; Becker, Skinner, Abel, & Cichon, 1986; Calhoun, Atkeson, & Resick, 1982; Ellis, Atkeson, & Calhoun, 1981; Feldman-Sumners, Gordon, & Meagher, 1979; Frank & Stewart, 1984; Frank, Turner, & Duffy, 1979; Gidycz et al., 1993; Johnson, Pike, & Chard, 2001; Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995; Kilpatrick, Best, Saunders, & Veronen, 1988; Kilpatrick, Resick, & Veronen, 1981; Kilpatrick et al., 1989; Kilpatrick, Veronen, & Resick, 1979; Mannarino & Cohen, 1986; Norris & Feldman-Summers, 1981; Polusny & Follette,
The most consistent predictor of sexual assault identified by the literature is a history of sexual victimization, either as a child or adult (Acierno et al., 1999; Cohen & Roth, 1987; Collins, 1998; Fisher et al., 2000; Gidycz et al., 1993; Gidycz, Hanson, & Layman, 1995; Greene & Navarro, 1998; Hanson, et al., 1995; Himelein, 1995; Kilpatrick, Acierno, Resnick, Saunders, & Best, 1997; Merrill et al., 1999; Messman & Long, 1996; Russell, 1986; Sorenson, Siegel, Golding, & Stein, 1991; Urquiza & Goodlin-Jones, 1994; Wyatt, Guthrie, & Notgrass, 1992). However, given that not every woman who is a sexual victim is necessarily revictimized in the future, and, thus, because future victimization may be prevented, the question of understanding the processes of revictimization becomes even more critical. Many of the theories yet proposed to explain revictimization focus on lack of cognitive resolution to the trauma (e.g., Foa, Ehlers, Clark, Tolin, & Orsillo, 1999; Foa & Riggs, 1993; Foa & Rothbaum, 1998; Horowitz, 1986; Janoff-Bulman, 1992; McCann & Pearlman, 1990; McCann, Sakheim, & Abrahamson, 1988).

Cognitive theories propose that because trauma deconstructs existing schemas about the self and the world, unresolved trauma, as indicated by lack of meaning making and reduced risk recognition and responsiveness, may, most problematically, increase a woman’s vulnerability to being revictimized (e.g., Cloitre, Scarvalone, & Difede, 1997). Although these cognitive models are helpful in conceptualizing the inner dynamic of a traumatized individual, they tend for the most part to neglect the social context in which a woman is embedded - a context posited to inculcate avoidance of the
trauma. In particular, the cognitive models as a whole seem to suggest that confrontation and meaning making are necessary for recovery (Greenburg, 1995); yet, contemporary America may disapprove of a woman who either acknowledges herself as a sexual victim or, moreover, socially confronts her grievance (Brownmiller, 1975; Burt, 1980, 1998; Gottfried, 1991; Harney & Muehlenhard, 1991; Muehlenhard & Linton, 1987; Rapaport & Burkhart, 1984; Russell, 1986). Instead, women are compelled through multiple mechanisms - be they self- or socially-inflicted, be they guilt or self-blame (Frazier, 1990; Janoff-Bulman, 1979; Koss & Burkhart, 1989) or the presiding legal system which fails to attend to these experiences as it would to any other crime (Bohmer, 1998; Donat & D’Emilio, 1998; Frazier & Haney, 1996; Koss, 2001; LaFree, 1989) - to avoid the necessary emotional intrusion that is, in theory, hypothesized to bring about cognitive resolution and, ultimately, promotion of future health.

The phenomenon of peritraumatic dissociation, that is, dissociative reaction during the time of trauma, has been demonstrated among various populations to predict subsequent PTSD symptomatology (e.g., Griffin, Resick, & Mechanic, 1997; Marmar, Weiss, Metzler, & Delucchi, 1996; Shalev, Peri, Canetti, & Shreiber, 1996; Ursano et al., 1999), and peritraumatic distress is also related to posttraumatic symptomatology (Brunet et al., 2001). Further, although the mediating role is not yet understood, aspects of PTSD have been demonstrated to increase a woman's risk of sexual victimization (Acierno et al., 1999; Sandberg, 1995). Presently, it will be argued that a woman who tends to immediately dissociate may become entrenched in an avoidant course - one in which she will, compelled both by the pain of schematic deconstruction and by a
society that ignores her experience, avoid her trauma and inadvertently stifle cognitive resolution.

Investigation of avoidance is lacking in the literature, perhaps in part because traumatized individuals who are primarily avoidant in their reactions are less likely than those who experience intense intrusions to be identified according to their symptomatology (Epstein, 1993). Lack of resolution to a trauma, born of avoidance, may demonstrate itself in a number of ways, including avoidant or dissociative posttraumatic symptomatology (Epstein, 1989, 1993; Griffin et al., 1997; Polusny & Follette, 1995), evidence of self-blame and other cognitive discord, lack of acknowledgment that a crime has occurred, and lack of meaning attributed to and growth from the situation (e.g., Janoff-Bulman, 1979; Tedeschi & Calhoun, 1996). Moreover, all of these outcomes potentially impose greater risk that a woman will be revictimized. Not only might peritraumatic experience signal the beginning of an avoidant psychological course, but the woman's social context, necessarily shaping her both prior to and subsequent to an assault, may further exacerbate this default cognitive coping strategy.

To investigate these hypotheses, 144 college women who had experienced at least one sexual assault involving completed intercourse since the age of 14 years filled out questionnaires related to their assault experiences, current symptomatology and cognitions, and the meaning or growth they had derived from their experiences. In addition, they took part in individual interviews about their assault experiences in order to obtain further information about their cognitive attributions, meaning making, and sociolegal responses. The participants returned for follow-ups \( M = 4.2 \) months, at
which time they reported on any sexual revictimization experiences that had occurred during the follow-up period. Using a prospective design, this study found that degree of peritraumatic dissociation indeed predicted avoidant and dissociative posttraumatic symptoms as well as cognitive discord, and, contrary to prediction, posttraumatic growth. Likewise, peritraumatic distress, which was highly related to peritraumatic dissociation, served the same predictive role in this process. Finally, a logistic regression analysis revealed that posttraumatic cognitive discord, but none of the other predictors considered in the present model, increased women’s risk of sexual revictimization during a 4.2-month follow-up period.

The Literature

_What Female Sexual Victimization Looks Like: A Contemporary Scope_

Since the early-1980s, research has mounted which corroborates that the pervasiveness of sexual victimization of women in America is a grave social truth. Some of the earliest published estimates of prevalence suggested that as many as 44% of the female population had experienced at least one episode of completed or attempted sexual assault (Russell, 1983), and other studies suggested that the college population might be at particular risk (Koss et al., 1987). In fact, the latter study found that across 32 U.S. institutions of higher education, 54% of women reported in behavioral terms a history of some form of unwanted sexual contact, and 25% reported having been the victim of rape or attempted rape. These figures, estimating that up to 1 in 4 women by college age have experienced either a rape or attempted rape and that at least 50% have experienced some sort of sexual assault, have been widely substantiated

Although long criticized for underestimating the incidence and prevalence of sexual assault due to inadequate methodological consideration (Koss, 1990, 1992, 1996), the federal government has recently answered the challenge of addressing these concerns. Federal researchers are acknowledging the significant weaknesses of prior data collection, including inadequate confidentiality provision, lack of specificity in instruments used to identify victims, and problematic methods (e.g., counting multiple victimizations within 6 months as a single victimization), each potentially contributing to underestimation of the scope of sexual assault (Tjaden & Thoennes, 2000). A recent national telephone survey, conducted by the National Institute of Justice (NIJ) and the Centers for Disease Control and Prevention (CDC) of 8,000 women age 18 and older, seems somewhat closer to defending the early estimates of the scope of victimization (Tjaden & Thoennes, 2000) – estimates that have resonated despite public skepticism (e.g., Roiphe, 1993) for over 20 years. This report found that 17.6% (or more than 1 in 6) women reported having been the victim of either rape or attempted rape at some point in their lifetimes and that 0.3% of women had been the victim of this caliber of assault within the past year (Tjaden & Thoennes, 2000). While these figures may still constitute an underrepresentation of the problem, even federal researchers now agree, these numbers substantiate “a major health and criminal justice concern in the United States,” and “violence against women is endemic” (Tjaden & Thoennes, 2000, p. v).

The problem with antiquated national crime statistics is that most instances of sexual victimization, known to exist because of studies that look at women’s histories of
assault in *behavioral* terms (Kilpatrick et al., 1987; Koss et al., 1987; Russell, 1982; Wyatt, 1985), are neither reported to police or otherwise entertained by the criminal justice system (Koss, 1985, 1988, 1998; Koss et al., 1987; Mynatt & Allgeier, 1990; Russell, 1982) nor are they even acknowledged by the victim herself (Kahn & Andreoli Mathie, 2000; Layman et al., 1996; Pitts and Schwartz, 1993). Koss (1985, 1988, 1998) has termed this phenomenon *hidden rape*, precisely because these victimizations have so often been historically overlooked. Potential contributors to the tendency of women, both in community and college samples, not to identify and report sexual assault are not yet completely understood. However, we do know that sexual victimizations are most often committed by someone close to a woman (Gidycz et al., 1993; Kilpatrick et al., 1988; Koss, 1988; Mynatt & Allgeier, 1990). Indeed, Gidycz et al. (1993) found that 92% of college women assaulted during a 9-week period were victimized by acquaintances, and others have estimated that almost 98% of rapes on college campuses are acquaintance rapes (Andreoli Mathie & Kahn, 1995; Kahn et al., 1994). Perhaps women are reluctant to implicate their friends, boyfriends, lovers, or male relatives as perpetrators of crime (Gidycz et al., 1993; Layman et al., 1996; Russell, 1982, 1983).

We also know that many women are assaulted in childhood and adolescence (Acierno et al., 1999; Berger, Delgado, & Gray bill, 1994; Cloitre, Tariff, Mazurka, Leon, & Porter, 1996; Kilpatrick, Edmunds, & Seymour, 1992; Russell, 1983), when they may be less emotionally and cognitively equipped to deal with trauma and are much less likely either to disclose their victimizations or to pursue them in a criminal context (Acierno et al., 1999; Finkelhor & Browne, 1985; Koss & Burkhart, 1989). In particular, Russell (1983) found that 38% of women in an American city reported
having experienced a sexual assault prior to the age of 18 years, and Kilpatrick et al. (1992) found that almost 61% of rapes occur prior to age 18. Furthermore, as previously mentioned, college seems to be a particularly high-risk time for sexual assault (e.g., Gidycz et al., 1993), and half of this population has experienced some kind of sexual victimization (e.g., Koss et al., 1987). A recent study conducted at a midwestern university found that among 589 women surveyed, 9.5% reported having been sexually assaulted and 3.7% reported having been the victim of either rape or attempted rape, even over a relatively short period of 9 weeks (Dowdall, 1999). Clearly, the youthfulness of its victims may be one factor contributing to the covert nature of acquaintance rape.

The most recent federal efforts to get at the real prevalence and incidence of sexual victimization on college campuses underscores many of the theoretical issues and empirical outcomes from the sexual assault literature of the past 30 years (Brener et al., 1999; Fisher et al., 2000). By focusing on detailing the wording of screening items in explicit behavioral terms and by framing studies as dealing with “unwanted sexual experiences,” rather than concerning “criminal victimizations” (emphasis my own), researchers have aimed to include those victims who might not otherwise report their experiences (Fisher et al., 2000, pp. 33-34). In fact, their efforts have paid off in catching victims who might have otherwise slipped through the net of unacknowledgment, given that previous national estimates of completed rape on college campuses had been 11 times smaller and estimates of attempted rape 6 times smaller than those obtained in the Fisher et al. (2000) study. Indeed, these researchers agree, colleges are “hot spots for criminal activity” (Fisher et al., 2000, p. 1).
Specifically, the Brener et al. (1999) study found that lifetime prevalence of rape among college women is 20%, 15% since age 15. Fisher et al. (2000) found that among 4,446 college women, 2.8% had been victim of rape or attempted rape over the course of the last school year ($M = 6.91$ months post-assault), and they projected that at this rate, 4.9% of women over the course of a calendar year and 20% to 25% of women over the course of their college careers would be the victim of either attempted or completed rape. While these incidence estimates seem to be more consistent than past ones with estimates from within academia, they are still, if anything, conservative.

A study with naval recruits suggests that we should not misattribute the problem of sexual assault to the college population alone. That is, of women recruits surveyed, fully 35% were found at the beginning of basic training to have been past victims of rape, a rate of victimization 2.4 times higher than that found in most college samples (Merrill et al., 1999). Nevertheless, national studies of college students have brought into focus a picture of what female sexual victimization in the contemporary United States looks like: a woman is as likely to be the victim of attempted/completed sexual coercion as she is to be the victim of attempted/completed rape (3% and 2.8%, respectively, over the course of just 7 months); (considering only victims of completed rape), she is as likely to say that she was not raped (48.8%) as she is to say that she was raped (46.5%); and, there is a 90% probability that she will have known her perpetrator (Fisher et al., 2000). After nearly 2 decades, national statistics seem to be substantiating 20 years of outcry from within the academy.
Risk Factors and Sequelae: Reciprocal Vulnerability

The term risk factor has traditionally been applied by the literature to characteristics of women that contribute some degree of variance to the probability that they will be sexually victimized. Notably, however, a minority of studies – although more in recent years – have focused on the perpetrator as a source of risk (e.g., Cornett & Shuntich, 1991; Layman, 1996; Ouimette & Riggs, 1998; Rapaport & Burkhart, 1984). Characteristics of women that have been identified as making them more vulnerable to sexual assault include emotional and psychological factors such as depression (Burnam et al., 1988; Greene & Navarro, 1998), antisocial personality (Burnam et al., 1988; Greene & Navarro, 1998), anxiety and phobias (Burnam et al., 1988; Greene & Navarro, 1998) and PTSD (Acierno et al., 1999; Sandberg, 1995). Also, women’s behaviors, such as multiple sexual partners (Greene & Navarro, 1998; Koss & Dinero, 1989), drug abuse or dependence (Brener et al., 1999; Burnam et al., 1988), and heavy and frequent alcohol use (Fisher et al., 2000; Gidycz et al., 2001; Greene & Navarro, 1998; Koss & Dinero, 1989; Muehlenhard & Linton, 1987) have often been cited as increasing their risk of sexual assault. Even women’s personal beliefs and interpersonal characteristics, such as holding traditional female values, passivity of communication, disinclination to resist, acceptance of violence against women, and token resistance to sexual pressure have been implicated as increasing their risk of sexual victimization (Amick & Calhoun, 1987; Bart & O’Brien, 1984; Muehlenhard & Linton, 1987; Murnen et al., 1989; Zoucha-Jensen & Coyne, 1993).

While these factors are important insofar as prevention programming can enable women to better protect themselves from assault (Cloitre, 1998; Yeater & O’Donohue,
prevention programming has yet been unsuccessful in reducing the rate of sexual victimization (Breitenbecher, 2000; Breitenbecher & Scarce, 1999) or in demonstrating progress in preventing revictimization (Breitenbecher & Gidycz, 1998). Moreover, the notion of prevention, per se, may be considered to be paradoxical by those who caution that movements to understand risk should avoid the tendency to find ways that the victim is to blame (e.g., Hanson et al., 1995). That is, inherent in identifying risk factors of the victim is the act of finding something within or about her that can be pointed to as contributing to her victimization. For example, in exploring a woman’s behavior, such as her alcohol use, research walks a tightrope between educating a woman about risk and implicating her, restricting her, or even blaming her once she has been victimized (having failed to act in the best empirically-validated way). Bublick (1999) has pointed out, “if a woman does not consent to sex, the fact that she did consent to a drink or the like should not make the rapist’s act ‘her fault’” (p. 1476), and, further, “women citizens have a legal entitlement to act on a day-to-day basis on the premise that others will not intentionally rape them” (p. 1443).

Acierno et al. (1999) has also cautioned that because sexual assault is undoubtedly a multi-causal event, it may be somewhat misleading to look at risk factors in isolation (e.g., race) without considering the necessary confounding factors of context (e.g., socioeconomic status, education, substance abuse, past victimization, etc.). Along these same lines, Koss and Dinero (1989), who attempted to compose an integrated vulnerability model of various important risk characteristics, concluded, “the vast majority of sexual assault victims could not be differentiated [and] rape vulnerability was either linked to earlier experiences beyond a victim’s control or was not
predictable...both circumstances [justifying] that most therapeutic sentence: ‘It wasn’t your fault’” (p. 249). Certainly, even among literature that looks at victim risk factors, it is agreed that there is little improvement over chance in predicting risk of sexual victimization based on factors about the woman (Abbey, Ross, McDuffie, & McAuslan, 1996; Himelein, 1995; Koss, 2000), and it must be recognized that sexual victimization could not and would not occur without the actions of the perpetrator.

Along these lines, it is also interesting to note that most of the same factors cited in the literature as increasing a woman’s risk for victimization are the same ones cited as consequences of sexual victimization. In fact, much of the risk factor literature may be confused by directionality of effect. This problem is highlighted by the abundant literature citing the correlates of childhood sexual assault, which, although bringing to light the unquestionable trauma imposed by such an experience, must also be necessarily viewed through a methodologically-limited retrospective lens. In these studies, women who report having been sexually abused as children show significantly higher levels of psychological distress, more prevalent psychological and personality disorders, and more maladaptive behavioral manifestations (e.g., Johnson et al., 2001; Mannarino & Cohen, 1986; Polusny & Follette, 1995; Sedney & Brooks, 1984) than women who do not report childhood victimization. While this canon of literature is compelling, it is possible, for example, that a person who is currently in distress may have a greater tendency to identify a history of assault than is a woman who has recovered psychologically from a similar past.

In a similar way, literature focusing on adult victimization can be ambiguous as to cause and effect. For example, while Burnam et al. (1988) found that depression,
anxiety, and substance use increase the risk that a woman will be assaulted, they also found that sexual assault predicts later onset of each of these. Furthermore, sophisticated multivariate analyses bring into question some of the traditional givens of the risk factor literature. For instance, Acierno et al. (1999) found that, controlling for factors such as demographic characteristics and substance use, depression is unrelated to increased risk of rape. Thus, no matter how risk factors may play into vulnerability, the important thing is that psychological manifestations born of sexual victimization, including depression (Atkeson et al., 1982; Ellis et al., 1981; Frank & Stewart, 1984; Frank et al., 1979; Gidycz et al., 1993; Kilpatrick et al., 1988; Steketee & Foa, 1987), fear and anxiety (Calhoun et al., 1982; Ellis et al., 1981; Gidycz et al., 1993; Kilpatrick et al., 1988; Kilpatrick et al., 1981, Kilpatrick et al., 1979; Steketee & Foa, 1987), anger (Kilpatrick et al., 1981), disrupted social and sexual functioning and satisfaction (Becker et al., 1986; Ellis et al., 1981; Feldman-Sumners et al., 1979; Kilpatrick et al., 1981; Norris & Feldman-Summers, 1981; Steketee & Foa, 1987) and PTSD (Kessler et al., 1995; Kilpatrick et al., 1989; Kilpatrick et al., 1987; Rothbaum et al., 1992), cannot be denied.

In particular, Kilpatrick et al. (1988) found that victims of rape were 11 times more likely to be clinically depressed and 6 times more likely to be fearful in social situations than were nonvictims, and Frank and Stewart (1984) found that 43% of rape victims experienced a depressive episode within one month of an assault. Kilpatrick, Veronen, and Best (1985) found that intrusion-avoidance symptoms are experienced up to 3 years subsequent to a rape in nearly 90% of victims, while it was estimated by another study that work adjustment was still affected at 8-months post-rape, ostensibly
because of trauma-related disturbances in functioning (Resick, Calhoun, Atkeson, & Ellis, 1981). By some accounts, trauma-related depression is likely to subside for many women after about 3 months (e.g., Frank & Stewart, 1984; Steketee & Foa, 1987), while fear reactions tend to persist (e.g., Steketee & Foa, 1987). Nonetheless, the net effects of victimization are obviously grave and deeply felt, as suicidal thoughts often linger as well (Ellis et al., 1981). It is estimated that up to one in five women who are raped attempt suicide, a rate 8.7 times higher than that for nonvictims (Kilpatrick, Best, Veronen, Amick, Villeponteaux, & Ruff, 1985).

Studies have used retrospective designs to demonstrate that the prevalence of sexual assault history in women seeking treatment for substance use disorders is significantly higher than for women who do not seek such treatment (e.g. Miller, Downs, Gondoli, & Keil, 1987). Again, however, the use of retrospective self-report does little to outline sequential development of such disorder. Thus, although abuse of alcohol has often been argued to increase the risk of future assault, prospective analyses have shed some questioning light onto the direction of this effect. As a case in point, Kilpatrick et al. (1997) interestingly found that abuse of alcohol did not increase the odds of victimization at 2-year follow up, but, rather, the odds of alcohol abuse increased (even for women with neither alcohol abuse nor assault histories) only after an assault had occurred. This study also found that for those women who did actively use substances at the beginning of the study, if an assault occurred during the study, risk of alcohol abuse tended to increase even further after the trauma had occurred (Kilpatrick et al., 1997). Clearly, the noxious effects of sexual victimization span the gamut of emotional, psychological, cognitive, behavioral, and physical domains, and
only a small minority of women are reported to be symptom-free within a year of assault (Burgess & Holmstrom, 1978; Veronen & Kilpatrick, 1983). Given this, and given the problems and potential social repercussions of identifying singular risk factors amidst victims’ complex lives, a sage conclusion for the vulnerability-sequelae literature as a whole is that most of these factors of well-being are likely to be both repercussions of, and contributors to, sexual victimization (Acierno et al., 1999; Gidycz et al., 1993). Furthermore, the ebb and flow of risk, victimization, and increased future risk is difficult to pin down because it is clearly multifaceted and, most likely, cyclic in nature.

**PTSD and Dissociation: A Focus on Avoidant Cognitive Response to Trauma**

One of the most commonly agreed on, but not fully understood, psychological sequelae to trauma – including sexual assault – is Posttraumatic Stress Disorder (PTSD). Research has consistently found that the prevalence of PTSD is higher among women who have been victimized than among those who have not (Cloitre et al., 1997; Hanson et al., 1995; Kessler et al., 1995; Kilpatrick et al., 1989; Kilpatrick et al., 1987; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993; Rothbaum et al., 1992). In particular, for women who experience a rape both perceived as life threatening and physically injurious, as many as 80% will develop lifetime PTSD (Kilpatrick et al., 1989). Furthermore, Kilpatrick et al. (1987) found that in a community sample of women, lifetime prevalence of PTSD was higher (57.1%) in women who had been victims of completed rape than for any other victim group. Similarly, Kessler et al. (1995) found in an epidemiological sample of the general population that of those women with PTSD, the traumatic event most commonly associated with upset was
sexual assault (49% for rape and molestation combined). Likewise, Arata and Burkhart (1995) found in their sample of 316 college women who had reported sexual assaults, victims reported significantly higher levels of PTSD symptoms than did non-victims. This study also found that cognitive appraisals and self-blame, but not type of assault, were associated with level of current PTSD symptomatology (Arata & Burkhart, 1995). These studies, taken together, demonstrate that women who have been sexually victimized are at high risk for developing PTSD, and, among women who have experienced PTSD, as many have been sexually victimized as have not.

PTSD, according to the American Psychiatric Association’s *Diagnostic and Statistical Manual*, characterizes a reaction of intense horror, fear, or helplessness to an extreme stressor, including sexual assault, which involves threat of or actual injury to one’s person (4th ed., text revision; *DSM-IV-TR*, American Psychiatric Association, 2000). The diagnosis requires that an individual engage in both persistent reexperiencing of, as well as avoidance of, a traumatic event. Reexperiencing may take the form of intrusive recollections, recurrent dreams, dissociative states, flashbacks, and/or physiological reactivity due to triggering events (APA, 2000). Although these symptoms are couched in terms of experiencing the trauma over again, the nature of these reactions – especially dissociation – seem ironically detached from the trauma. That is, dissociation has been described as an alteration of conscious experience such that affectively laden traumatic events are *not accessible to awareness*, and dissociation has been posited to be a common mechanism for insulating one’s self from a trauma (Putnam, Guroff, Silberman, Barban, & Post, 1986). In this respect, *reexperiencing* seems to be somewhat of a misnomer to the extent that an individual may actually
avoid, by the cognitive process of dissociation, actual emotional reexperiencing of the event.

The ways in which the *DSM-IV-TR* describes *persistent avoidance*, however, seem, on the whole, more internally consistent. They include:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. a feeling of detachment or estrangement from others
6. restricted range of affect, and
7. a sense of a foreshortened future. (APA, 2000, p. 468)

Indeed, all of these descriptors, any three of which characterize an individual with PTSD, give an impression of – whether in action, feeling, thought, or livelihood – restriction on, or avoidance of, something previously important to the victim’s self. That is, these avoidance patterns seem exhausted of feeling for the world (criteria 1, 2, 4, and 5), devoid of selfhood (criteria 1, 2, 3, and 6); and barren of vitality (criterion 7). Not surprisingly, PTSD is associated with increased rates of depression, substance-related disorders, and various anxiety disorders, including panic and social phobia (APA, 2000).
An additional criterion of PTSD is persistent anxiety or increased arousal (APA, 2000). It has been well-understood for some time that anxiety and fear are associated with fight-or-flight reactions, that is, autonomic system arousal, including increased blood pressure, heart rate, and respiration (e.g., Cannon, 1932; McCann et al., 1988). Selye (1976) found that when animals were unable to escape harmful stimuli, an exhaustion phase ensued, and permanent damage to the adrenal glands and chronic hypersensitivity to stressful stimuli resulted. As a result of the real or perceived inescapability of trauma, women who have been sexually victimized may be biologically programmed to react with hypervigilence and general fear. In this light, it is not surprising that many women respond to assault with decreased trust of men and fear of becoming involved with them (e.g., Ellis et al., 1981). Neither would it be surprising – given the indiscernability of danger from non-danger implicit in chronic arousal – that their biological reactivity to another threatening situation might be compromised.

There is also research that points to a history of trauma bearing strong impact on dissociative symptomatology apart from PTSD. For example, Herman, Perry, and van der Kolk (1989) found that history of childhood trauma, even more than adult borderline diagnosis, is associated with dissociative adulthood borderline personality disorder (BPD). Also, in line with his study of incest victims with dissociative disorders who had been sexually exploited by their therapists, Kluft (1990) suggested that dissociative symptoms indicate a vulnerability to repeated victimization. Given that 78% of his sample had been revictimized as adults, Kluft concluded that these individuals were seemingly incapable of reacting to subsequent danger situations. In this sense, dissociation has been conceptualized as a “two-edged sword,” nearly
essential in coping with the overwhelming impact of trauma, yet leaving the individual particularly vulnerable to debased cognitive functioning and sexual victimization (Kluft, 1990, p. 167). More specifically, Kluft (1993), discussing individuals with multiple personality disorder (MPD) – now better known as dissociative identity disorder (DID; APA, 2000) – postulated that severe trauma overwhelms individuals’ abilities to use nondissociative defenses and that this inability is compounded by a lack of protective and restorative experiences to facilitate healing. Also lending support to Kluft’s model of avoidant dissociation, estimates of history of childhood or adolescent abuse, particularly sexual assault, for patients with MPD have ranged from 85% to 90% (Putnam et al., 1986).

Cloitre et al. (1997) found that women with a history of both childhood and adulthood sexual victimizations reported more dissociative symptoms than did women who were assaulted only in adulthood. This finding lends credence to Cloitre’s (1994) theory that dissociatively-inclined women are less aware of the risks around them due to emotional numbing and are, thus, less likely to take action to avoid or escape threat. Cloitre and colleagues (1997) describe assaulted women’s inability to recognize and differentiate internally generated alarms to dangerous situations, especially typifying women who have been victimized multiple times (and who may be even more prone to dissociate). Along similar lines, Waller, Quinton, and Watson (1995) found that women with higher levels of dissociation took longer to recognize threatening words in a word identification task. Thus, dissociation has been conceptualized as an often engaged, yet not wholly beneficial, coping mechanism for individuals who suffer trauma.
Peritraumatic Dissociation: A Marker of Avoidant Cognitive Style?

Marmar, Weiss, and Metzler (1997) corroborate an important aspect of Spiegel and Cardena’s (1991) review of dissociative disorders in linking dissociation during a traumatic event to future dissociative symptomatology. The former study explains, “dissociation at the time of [trauma] may be a mechanism to cope with overwhelming traumatic events” (Marmar et al., 1997, p. 413). What is brought to light by these words is that the dissociative coping experience may begin within a victim as soon as the realization of the trauma begins to take root, that is, even as the trauma is occurring. Furthermore, this real-time dissociation often seems to be predictive of later dissociative symptoms, a strategy that arguably constitutes an avoidance pattern. Such an experience, in which the victim engages in immediate, acute dissociation, including altered time sense, feelings of unreality, depersonalization, out-of-body experience, disorientation, and altered physical perception of self, is known as peritraumatic dissociation (Marmar et al., 1997). These same types of immediate reactions to traumatic experience have been substantiated for some time in a number of empirical investigations, including that of Noyes and Kletti (1977), which reported that of 101 survivors of automobile accidents, 66% reported five or more features of depersonalization at the time the trauma was occurring. Likewise, Hillman (1981), Wilkinson (1983), and Siegel (1984) have found similar reactions in correctional officers held hostage, hotel skywalk collapse survivors, and kidnapping hostages, respectively, suggesting that dissociative phenomena, even at the time of trauma, may be experienced in order to cope with the shock and gravity of the immediate circumstance.
Sometimes, as with many victims of the 1989 Loma Prieta earthquake in the Bay Area, California, acute dissociation can occur at the time of or soon after the trauma (up to 1 week later) but then dissipates with time (by 4-month follow-up), considered by researchers to indicate a transient dissociative phenomenon (Cardena & Spiegel, 1993). However, it has more generally been established that dissociation during a trauma is also a predictor of longer-term posttraumatic symptomatology. For example, one study found that dissociative symptoms (even more than anxiety or loss of personal autonomy symptoms), experienced immediately in the aftermath of a fire, predicted posttraumatic symptomatology 7-9 months after the event (Koopman, Classen, & Spiegel, 1994). Given the persistence of posttraumatic symptoms, the long-held belief that dissociation in response to trauma is an adaptive mechanism, one that allows the victim of a highly threatening circumstance to confer feelings of distance and safety and to diminish feelings of helplessness and terror, begs for a contemporary caveat (Marmar et al., 1997). That is, in contrast to this perspective of dissociative adaptation, the brunt of the literature suggests that peritraumatic dissociation may in fact dispose victims to subsequent dysfunction, namely PTSD. In fact, Griffin et al. (1997) has found that an objective physiological pattern exists in individuals who engage in high levels of peritraumatic dissociation: they suppress autonomic physiological responses and often meet PTSD criteria.

When a relationship was discovered in male Vietnam veterans between peritraumatic dissociation and posttraumatic stress (Marmar et al., 1994), Marmar and colleagues endeavored to develop an instrument, the Peritraumatic Dissociative Experiences Questionnaire (PDEQ; Marmar, Weiss, Metzler, Ronfeldt, & Foreman,
1996), to systematically assess the implications of peritraumatic dissociation for various populations of trauma victims (see Appendix F). These latter authors found that for rescue workers who responded to a freeway collapse, the greater the level of peritraumatic dissociation (as measured by PDEQ score) during a San Franciscan earthquake, the greater the likelihood of meeting current PTSD criteria. They also found that the PDEQ-Rater Version had high internal consistency and that, even beyond the contributions of war-zone stress and general inclination to dissociate, dissociation during the trauma significantly accounted for PTSD determination (Marmar, Weiss, Metzler, Ronfeldt, et al., 1996). In sum, the first systematic use of the PDEQ demonstrated its reliability and validity in the assessment of predictive peritraumatic dissociation.

Lending further support to the predictive validity of the PDEQ, a similar relationship between peritraumatic dissociation and posttraumatic stress has been demonstrated for other traumatized populations, including emergency services personnel (Weiss, Marmar, Meztler, & Ronfeldt, 1995) and female Vietnam veterans (Tichenor, Marmar, Weiss, Metzler, & Ronfeldt, 1996). In the latter study, the first time the PDEQ had been used to assess peritraumatic experience in women, posttraumatic stress symptomatology was measured by the Impact of Event Scale (IES) and general dissociative tendency was measured by the Dissociative Experience Scale (DES), each of which were strongly associated with total PDEQ score. The Tichenor et al. (1996) study is important to the present study because the PDEQ was first demonstrated to be a useful measurement for a female traumatized population. As a whole, the aforementioned studies conducted by Marmar and his colleagues suggest that
peritraumatic dissociation is associated with traumatic stress response and general dissociative tendencies. Over the course of the past 10 years, the relationship between peritraumatic dissociation and posttraumatic dissociation has been verified by others. For example, Bremner et al. (1992) found that Vietnam War veterans with higher levels of current posttraumatic dissociative symptoms according to the DES had had higher levels of peritraumatic dissociative symptoms as measured by the PDEQ.

Particularly telling was the first prospective study using the PDEQ, in which peritraumatic dissociation was measured only 1 week after subjects had been admitted to a hospital for injury due to a traumatic event (Shalev et al., 1996). This study addressed the concern that biased recall of peritraumatic dissociation in individuals experiencing posttraumatic symptomatology had in previous retrospective studies been accounting for the strong associations between the two constructs. Providing evidence to disconfirm this possibility, Shalev et al. found that peritraumatic dissociation predicted 29.4% of the variance in PTSD symptomatology at 6-month follow-up. This study also found that 1-week scores on the IES were predictive of 6-month PTSD status and that avoidance symptoms according to the IES, in particular, intensified in those who developed PTSD (Shalev et al., 1996).

Since this initial prospective study of peritraumatic dissociation, others have demonstrated similar results. For example, victims of serious motor vehicle accidents assessed for peritraumatic dissociation with the PDEQ were followed up at 1 and 3 months, and those individuals who had experienced peritraumatic dissociation were found to be 4.12 times more likely to have acute PTSD and 4.86 times more likely to
have chronic PTSD than individuals who did not experience peritraumatic dissociation (Ursano et al., 1999). Based on a longitudinal analysis of the aforementioned emergency services personnel who responded to a freeway collapse, Marmar et al. (1999) concluded that given that PDEQ scores predict symptomatology even at 3.5-year follow-up, individuals who experience peritraumatic dissociation are at chronic risk for symptomatic distress. These prospective studies more conclusively show the predictability of later development of posttraumatic symptoms based on peritraumatic dissociation.

Avoidance as a Conceptual Path to Posttraumatic Symptomatology in Victims of Sexual Trauma

It has been widely suggested that risk factors for the development of PTSD following a sexual assault include comorbid depression and other psychopathology, alcohol abuse, and injury during rape (Acierno et al., 1999; Breslau, Davis, Andreski, & Peterson, 1991; Kessler et al., 1995). Further, it has been proposed that these factors may either function to lower the threshold at which a victim experiences PTSD symptoms or that anxiety and affective disorders may simply tend to coexist with, and thus maintain, PTSD symptomatology (Acierno et al., 1999). Corroborating the prevalence of this comorbid posttraumatic phenomenon, Breslau et al. (1991) reported that up to 80% of people with PTSD also have at least one other psychiatric disorder. Interestingly, the comorbid factors presumed either to increase the chances of developing PTSD or to contribute to its maintenance (i.e., injury, depression, alcohol abuse) all involve blunted affect. That is, this comorbid cluster seems to be characterized by emotional avoidance (Polusny & Follette, 1995). Indeed, the path to
development of posttraumatic symptoms may be through mechanisms that are conceptually anesthetic, or avoidant, in nature.

Although this avoidant path makes conceptual sense, the dearth of research to date that looks at the effect of peritraumatic dissociation on the development of PTSD in victims of sexual assault makes such a model empirically inconclusive. Nonetheless, two studies with rape victims have found that level of peritraumatic dissociation is predictive of posttraumatic stress level (Boles, 1996; Griffin et al., 1997). Griffin et al. (1997), in fact, found that of individuals in a high peritraumatic dissociation group, 94% were identified as meeting PTSD symptom criteria, and, moreover, this group differed from the low peritraumatic dissociation group in physiological indicators, particularly in that they suppressed autonomic arousal. Based on these findings, the authors proposed the existence of a dissociative subtype of persons with PTSD, characterized by “the chronic use of dissociative mechanisms as a means of dealing with the trauma…[leading] to a failure to process the trauma cognitively and emotionally and therefore [resulting] in more severe posttrauma reactions” (Griffin et al., 1997, p. 1081). Clearly, investigation using prospective analyses would shed further light on both the existence and nature of such a subtype.

This concept seems to be in agreement with Spiegel, Hunt, and Dondershine (1988), who concluded that PTSD might better be conceptualized as a dissociative disorder than an anxiety disorder, and with Epstein (1989, 1993), who has noted the “self-cloaking” nature of avoidant symptoms which, he posits, may lead to the problem of false negatives in the diagnosis of PTSD. Moreover, another study found that avoidance just after a trauma was a better predictor of chronic intrusive
symptomatology than was initial intrusion, and the authors proposed the following explanation:

Avoidance behavior often short-circuits [the healing process] by preventing a complete reexperiencing of all thoughts, images and related effects, while the reduction of immediate distress and arousal negatively reinforces this behavior. In addition, the repeated negative reinforcement of avoidance behavior makes it very resistant to extinction. By continuing the pattern of avoidance, these symptoms are not only maintained but can worsen over time. (Lawrence, Fauerbach, & Munster, 1996, p. 643-644)

Given that avoidance may indicate chronic symptomatology, and given the converging agreement that avoidant-type dissociation may be so elusive as to have been overlooked in previous investigations, it would be useful to discover whether peritraumatic dissociation is a marker for individuals who will engage this type of cognitive coping strategy. Indeed, not only has Marmar et al. (1994) found a strong relationship between peritraumatic dissociation and the avoidance subscale of the IES, but Griffin et al. (1997) has additionally found that peritraumatic dissociation scores are strongly correlated with PTSD Symptom Scale avoidance scores. The latter authors conclude, “the link between dissociation and general avoidance of the trauma deserves further study” (p. 1086).

Only one study to date has followed the conceptualization of peritraumatic dissociation, through the path of posttraumatic dissociation, to prospectively evaluate revictimization (Pashdag, Dowdall, & Gidycz, 1999). While this study did not support the predicted hypothesis that peritraumatic dissociation during adolescent assault would
predict future revictimization, it nonetheless raised a number of interesting questions. For example, the authors suggested that the use of a more extensive measure of physical dissociation in response to assault, such as the Somatoform Dissociation Questionnaire (Nijenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1996), might have yielded an interesting picture of the effect of paralysis and immobility during the victimization on future vulnerability (Pashdag et al., 1999). Along these same lines, it would be useful to investigate the effect of peritraumatic distress using the Peritraumatic Distress Inventory (PDI; Brunet et al., 2001), very rarely looked at before and never before with a sexual assault population, on future vulnerability. The PDI is a measure of level of distress during the trauma, developed because of the lack of previous focus on this concept despite its inclusion as an essential criterion for PTSD (Brunet et al., 2001).

Additionally, it should be noted that Pashdag et al. (1999) operationalized dissociation in terms of scores on the DES rather than looking in particular at avoidance symptomatology. While a replication of this study with the DES at a longer follow-up time is warranted, given that avoidance may be particularly predictive of longer-term posttraumatic distress, a focus on avoidance scores, such as those obtained with the IES, might illuminate this aspect of peritraumatic and posttraumatic experience and its implications for revictimization. One interpretation of this avoidant course, were it to be established, would be that peritraumatic dissociation is an immediate marker of individuals with low thresholds for integration of the painful cognitions associated with the trauma. Furthermore, this perpetual dissociation and avoidance might help identify those individuals who are more vulnerable to future revictimization.
Prevention of revictimization is not merely an academic concern, given that of all the aforementioned factors that increase a woman’s risk of being sexually assaulted, the most well-established to date is a history of past victimization. That is, a woman who has been previously sexually victimized at any point during her life need not only deal with the emotional, social, and/or physical consequences of the assault, but, statistically speaking, she is at greater risk of being revictimized than her never-victimized cohorts. Multiple researchers have verified this phenomenon in both college and community samples (Acierno et al., 1999; Cohen & Roth, 1987; Collins, 1998; Fisher et al., 2000; Gidycz et al., 1993; Gidycz et al., 1995; Greene & Navarro, 1998; Hanson et al., 1995; Himelein, 1995; Kilpatrick et al., 1997; Merrill et al., 1999; Messman & Long, 1996; Russell, 1986; Sorenson et al., 1991; Urquiza & Goodlin-Jones, 1994; Wyatt et al., 1992). The first of these studies to perform a prospective analysis to evaluate revictimization (Gidycz et al., 1993) set an important precedent in addressing concerns voiced by Harney and Muehlenhard (1991), among others, who have suggested that retrospective analyses of revictimization may be tainted by differential remembrance of past assaultive experience by those who have been more recent victims.

In addition to knowing from retrospective analyses that as many as 50% of rape or attempted rape victims have histories of sexual victimization (Ellis, Atkeson, & Calhoun, 1982; Miller et al., 1978; Russell, 1983), prospective, longitudinal analyses have underscored this by finding that women who have been previously victimized are up to 2 times more likely than non-victims to be victimized even over the course of a
single academic quarter (Gidycz et al., 1993; Gidycz et al., 1995). Furthermore, in a national study that found that .3% of women had been raped during the previous year, the mean number of victimizations for these individuals was 2.9 ($SD = 1.431$; Tjaden & Thoennes, 2000). Others have found that as many as 66% of assault victims have been victimized more than once, with the average number of incidents per individual being 3.2 (Sorenson et al., 1991).

Although estimates of the general prevalence of child sexual abuse have ranged from 19% to 38% (Finkelhor, 1997; Russell, 1984), it is not likely, as some have suggested, that high base rates of childhood sexual assault alone explain the prevalence of revictimization (e.g., Mandoki & Burkhart, 1989). Specifically, Ellis et al. (1982) found that of their sample of 117 women at rape crisis centers, 21% had been previously victimized since the age of 14, and another study found that precollege sexual victimization while dating (usually an adolescent, not childhood, activity) was one of the most powerful predictors of revictimization in college (Himelein, 1995). Also refuting the notion that a high base rate of childhood sexual abuse accounts for the prevalence of adult revictimization, a recent study of college women found that while adolescent sexual victimization was related to adult sexual victimization, child victimization was not (Dowdall, 1999). Various theories have been proposed to explain revictimization, but empirical findings are yet to support any of them with certainty. Nonetheless, continued evaluation of the insights contributed by existing theories, rigorous reexamination and revision of them, and, perhaps, expansion of them may be critical to interrupting the cycle of revictimization.
Cognitive Processing Theories of Trauma: How Avoidance May Play Into Revictimization

Many theoretical positions, from repetition compulsion to deficit in risk recognition, have been posited in an attempt to explain sexual revictimization (e.g., Cloitre et al., 1997; Finkelhor & Browne, 1985; Mandoki & Burkhart, 1989; Messman & Long, 1996; van der Kolk, 1989; Wilson, Calhoun, & Bernat, 1999; Wyatt et al., 1992). In particular, several cognitive theories of trauma are useful in developing models of revictimization (Foa et al., 1999; Foa & Riggs, 1993; Foa & Rothbaum, 1998; Horowitz, 1986; Janoff-Bulman, 1992; McCann & Pearlman, 1990; McCann et al., 1988). Post-traumatic adaptation, according to cognitive processing theory, requires that traumatized individuals work to mold information forced onto them by the trauma into ready cognitive frameworks or schemas (Greenburg, 1995). According to this theory, repeated comparisons between the two sets of information, in the form of cognitive intrusions, should ultimately allow for some sort of resolution – either in reappraisal of the trauma or schematic revision. The cognitive theorists seem to say that posttraumatic intrusions, although painful in content, are ultimately adaptive (e.g., Horowitz, 1986), and others emphasize that exposure to and/or confrontation with traumatic memories is necessary to cross the bridge to recovery (Foa, Molnar, & Cashman, 1995; Pennebaker, 1990). Still, others caution that there may exist a threshold beyond which cognitive intrusion and search for meaning are no longer adaptive; yet, even these theorists acknowledge that some degree of intrusion is necessary for cognitive integration of trauma (e.g. Silver, Boon, & Stones, 1983). In this light, peritraumatic dissociation, subsequent dissociation, and other signs of lack of resolution
may be markers of a sort of cognitive avoidance that disallows ultimate concert between
the trauma and existing schema.

Horowitz (1986) has theorized that in addition to intrusion being an adaptive
response to stress, the counterpart mode of suppression (i.e., denial, numbing, and
avoidance) develops as medication for the pain of intrusive repetition. That is, because
intrusions are often emotionally intense and taxing, survivors can only handle them in
doses. Although these two cognitive mechanisms are posited to exercise separate
functions, in working through the traumatic experience, intrusion and suppression
counterbalance each other by means of alternation and, ultimately, decreased intensity
of intrusions, mood stability, and acceptance are achieved (Horowitz, 1974).
Completion, which is resolution between the discordant memories born of the trauma
and the information of preexisting schemata, signals the closure of the psychological
adaptation process (Horowitz, 1975). By Horowitz’s model, intrusions are adaptive
because their automaticity ultimately ceases, in concert with a new cognitive revision
that assimilates new and old information (1979). While Horowitz’s theory is successful
in attending to the internal posttraumatic dynamic, alternating intrusions and avoidance
that together afford cognitive resolution, it is acknowledged that his model pays
relatively little attention to the context external to the victim (Greenburg, 1995).

Janoff-Bulman (1989, 1992), like Horowitz, says that our schemas contain our
deeply held understandings about the way the world, and our selves within it, work.
When a trauma occurs, our first natural reaction is to attempt to place the experience
into the mold of what we already believe; only if our efforts to make it fit fail will we
resort to schematic restructuring. More specifically, according to Janoff-Bulman (1989),
individuals make the following three assumptions: the world is benevolent (i.e., other people are, on the whole, moral and trustworthy), the world is meaningful (i.e., it is fair and guided by rules), and the self is worthy of living within it (i.e., the self is either in control or lucky). It is these three deeply held beliefs that trauma undermines, and, as a result, conceptual systems are turned on their heads and must be reevaluated. Within this framework, we can imagine that for the survivor of sexual victimization, others may suddenly seem full of malice and the rules governing them deceptively transparent; selfhood may crumble to feelings of dyscontrol. It has been suggested that this deconstruction of life assumptions may be particularly salient for victims of acquaintance assault, having been betrayed by someone previously trusted and necessitating a unique coping challenge (Gidycz & Koss, 1991). The sense of betrayal, stigmatization, powerlessness (Finkelhor and Browne, 1985), guilt, and self-blame (Frazier, 1990; Janoff-Bulman, 1979; Koss & Burkhart, 1989) – all derivatives of the upheaval of Janoff-Bulman’s three assumptions – may feel like a world, a self, has collapsed. The yet-misunderstood skill of the successful survivor is to make sense of the trauma while keeping the assumptions somewhat intact (Janoff-Bulman, 1989).

According to Janoff-Bulman and Frieze (1983), a victim must not only confront the question, “why did this happen to me?” which often leads to self-blame, but she must also ultimately answer the question, “for what end?” (p. 6 and p. 135, respectively). Three resultant cognitive construals have been proposed that may bring about positive outcomes: lessons about life (i.e., a spiritual or moral message concerning living), lessons about self (i.e., beliefs of courage, dignity, and resilience involved in overcoming the trauma), and perception of benefit to others (e.g., helping
others who have been through similar experiences). This conception of trauma as an opportunity for growth is an exciting aspect of Janoff-Bulman’s theory, although the potential detrimental effects of holding illusions of recovery and growth have also been the subject of theoretical caution (Greenberg, 1995; Horowitz, 1988; McCann & Pearlman, 1990). Nonetheless, the question of growth from trauma is an interesting one and is deserving of empirical evaluation. Moreover, as Greenberg (1995) points out, Janoff-Bulman, as compared to Horowitz, seems somewhat more focused on the potential impact of social context. That is, Janoff-Bulman specifically recognizes that “those close to the victim provide the most potential data available about the nature of the world and the worth of the individual victim, at a time when a victim is particularly sensitive to such information” (1992, p. 146). Despite this insight, the present author would argue that although the recognition of close-knit social support is an important step toward the integration of context into cognitive theory, ecological considerations of the widespread phenomenon of sexual assault must go even further in considering the vast impact of culture on the sexual victim in particular.

Even more theoretically mindful of social context is McCann and Pearlman’s (1990) constructivist self development theory (CSDT), which emphasizes that it is the interaction of personal vulnerability with the situational conditions of the trauma that is important to an individual’s post-trauma adaptation. Moreover, this theory posits that the individual is active in her creation and construal of reality and in the recreation of posttraumatic cognitive schema. That is, while the psychological and behavioral risk factors an individual brings to a situation may be important, the event itself – embedded in a social context – is just as contributory (McCann & Pearlman, 1990). Much like
Horowitz and Janoff-Bulman, McCann and Pearlman believe that when a person experiences a trauma that is both highly distressing and disrupting of the concepts of self and world, it is the personal meanings applied to the images of the event that are important to conceptualization of and adaptation to the trauma. That is, “trauma, by definition, requires accommodation, or a modification in schemas. . . [and] individuals often attempt to avoid the process of accommodation because the transformation of inner models of self and world is extremely disruptive psychologically” (McCann & Pearlman, 1990, p. 7). The schemas McCann and Pearlman speak of – which are jeopardized by traumas including sexual victimization – include frame of reference, safety, trust/dependency, independence, power, esteem, and intimacy. Resolution to the traumatic deconstruction of these schemas may include making positive meaning of the trauma, such as transforming the experience into a gift for others or the world or an impulse to improve the spiritual dimensions of one’s life (McCann & Pearlman, 1990).

While most cognitive theorists consider differences between victims and nonvictims, others differentiate among survivors (Foa et al., 1999; Foa & Riggs, 1993; Foa & Rothbaum, 1998), positing that PTSD indicates disruption in the normal process of recovery and is based on the two assumptions that the world is completely dangerous and that the self is totally incompetent. The possession of these markedly rigid beliefs – rather than beliefs that are shades of gray (e.g., the trauma was a unique experience that can be coped with) – is the catalyst for symptomatic development (Foa et al., 1999). This broader concept, that the meaning derived from the experience is critical, is also espoused by Ehlers and colleagues, who posit that derived meaning determines whether the victim sees a traumatic experience in time-limited or time-unlimited terms and
whether it is interpreted as an idiosyncratic event with associated sequelae or a persistent threat with global implications (Ehlers & Clark, 2000). One study found that overall feelings of alienation or permanent change following trauma were correlated with poorer outcomes (Ehlers et al., 1998). Excessively negative appraisals of meaning – because they may promote overly generalized fear, anger, guilt, shame, and sadness, and, thus, avoidance – are conceptualized not to allow for personal growth (Ehlers & Clark, 2000). Moreover, persistence of negative appraisals has been shown to maintain PTSD (Dunmore, Clark, & Ehlers, 1999; Ehlers & Clark, 2000).

Although intrusive posttraumatic symptoms are generally the relative focus of cognitive theories of trauma (see Greenberg [1995] for a review), lack of empirical focus on avoidance is perplexing, given the role that it is acknowledged to play in the maintenance of PTSD. For example, Ehlers and Clark (2000) describe maladaptive cognitive coping strategies, including thought suppression, superfluous safety behaviors (taken to prevent future catastrophes), trying not to think about the event, avoiding reminders of the trauma in an effort not to be reminded of it, using alcohol and medication to control anxiety, and giving up or avoiding pre-trauma activities, which are intricately related to increased PTSD symptoms. In contrast, PTSD-related arousal symptoms have even been hypothesized to serve a buffering role, actually increasing sensitivity to threat cues in date rape scenarios (Wilson et al., 1999). Cohen and Roth (1987) emphasized that while neither approach nor avoidance coping strategies were positively associated with recovery on any of their outcome measures, avoidance, in particular, was found to be associated with worse outcomes on several measures. They posit that there is something distinctive about sexual victimization – because of the
obvious pervasiveness of assault reminders (e.g., sex, violence in the media, and men) – that makes avoidance as a coping strategy so ineffective (Cohen & Roth, 1987).

Another line of research that indirectly illuminates the potential problems of avoidance as a primary coping strategy is trauma recovery processes. Pennebaker and his colleagues have found that writing about trauma in an emotional way benefits the writer by means of providing narrative structure and mental health (Harber & Pennebaker, 1992; Pennebaker, Mayne, & Francis, 1997; Pennebaker & Seagal, 1999). Pennebaker (1997) posits that the mere act of constructing an emotional narrative about a traumatic event allows a person to cognitively organize the trauma in a way that allows placement of the experience in the past where it no longer need be actively avoided. The opportunity for emotional expression – that is, emotionally open self-disclosure – seems to be key to subsequent schematic integration. In other words, the more highly emotional the disclosures, the better the ultimate outcomes of mood and cognition for the individual. In a similar way, cognitive and behavioral therapies for victims of trauma have focused on elaborating and integrating the experience into the individual’s context, reappraisal of current sense of threat, reliving the experience with the therapist or through words, and even in vivo exposure (e.g., Ehlers & Clark, 2000; Foa & Rothbaum, 1998). These strategies as a whole seem to reason that the effective mechanism for cognitive healing involves some exposure to, and certainly not mere avoidance of, the emotionally painful experience.

Pennebaker and colleagues’ studies have shown that elaborating or reexperiencing a trauma in an emotional way through writing can bring about not only positive therapeutic benefits but also improvement in physical health. While these
studies do not usually specify the quality or magnitude of trauma – arguably reflecting a relatively mild operational definition – their results seem to indicate that even more highly traumatic experiences (e.g., sexual assault) may be more highly influenced by writing therapy. Specifically, drops in clinic visits for subjects who wrote about highly traumatic experiences (Pennebaker & Beall, 1986) were even more dramatic than benefits accrued by those who wrote about relatively mild traumas (Greenberg & Stone, 1992). Francis and Pennebaker (1992) found that individuals who wrote about traumas once a week for 4 consecutive weeks experienced in the 2 months following their experiment fewer absentee days and improved liver enzyme functioning, compared with control subjects. Also, people who experienced job loss were better at coping with the loss if they wrote expressively than if they did not (Spera, Buhrfeind, & Pennebaker, 1994).

While heightened emotional experiencing is considered to be central to positive therapeutic health change, these intense expressions in themselves are understood not so much to be a reparative endpoint but instead a catalyst for cognitive reconstruction. That is, emotionality is at once necessary, but not sufficient without cognitive restructuring, to induce positive clinical effects. Gendlin (1991) says that deep emotional experiencing must occur but, also, the emergent affective material must be examined in order to understand self and environment. McGuire (1991) further explores the necessity of preverbal, instinctual emotion in bringing us, through “felt experiencing,” to a place of reevaluation and reconstruction of our higher order meanings (pp. 228-229). According to this theory, emotion and cognition synergistically work to provoke resolution to trauma.
Esterling, L’Abate, Murray, and Pennebaker (1999) suggested some possibilities, based on cognitive theory, for why coherence and emotional reflection may be so important in ultimately putting away a trauma. These authors say that by making an event more cognitively accessible through writing, the event, in turn, becomes more automatic, less effortful to access, and, thus, less traumatic to conjure up. They further suggest that in the activity of communicating a trauma through words, a person is forced to make sense of it, at least in terms of making it a coherent story, perhaps even attributing some causality to the circumstance (Esterling et al., 1999). These suggestions would seem to be corroborated by the Pennebaker (1989) study, in which subjects who wrote about traumas spontaneously reported thinking about the events with new perspective. Also, given that causal and insight words found in writings predicted improved health (Pennebaker et al., 1997), it is apparent that the benefits of writing come to some extent from piecing disparate pieces of a trauma into a coherent whole. What we must consider, according to Hartman and Burgess (1993), is that traumatic events “break down the capacity of the human being on a physiological and on a psychological level to regulate emotional states and consequently ideational cognitive states” (p. 514). Perhaps the mere process of grappling with trauma, rather than avoiding it, allows for some cognitive groundedness, an intact schema, into which the disruptive emotionality of sexual assault can begin to settle.
Sociolegal Dissociation: The Prevalence of Unacknowledged Victimization and the Context of Cognitive Avoidance

Looking with a broader social scope at the problem of avoidance, lack of resolution, and revictimization, these phenomena seem to come into focus and, contextually, make sense. It has been argued (e.g., Brownmiller, 1975) – though there is little research focus on such – that the greatest risk factor for sexual assault may be contemporary America’s culture of permissiveness of sexual assault. In fact, the United States appears to be one of the most rape-prone of modern societies, with an incidence of reported rape that has been estimated to be 18 times higher than that of England or Wales (West, 1983). Arguably, rape and other sexual victimization is not so much a human problem but, rather, largely a cultural one. Among contemporary social concerns, some emphasize the power differentials between men and women that still exist (Gottfried, 1991; Harney & Muehlenhard, 1991), while others have found that social rape myths (e.g., women who wear short skirts are looking for sex, women secretly want to be raped) not only persist but may contribute to the problem of sexual aggression (Burt, 1980, 1998; Muehlenhard & Linton, 1987; Rapaport & Burkhart, 1984). Theories that go beyond victim-blaming in looking at explanations for victimization are those that are most mindful of the social atmosphere of impassiveness with regard to sexual assault (e.g., Brownmiller, 1975; Russell, 1986). On a smaller scale, it is generally acknowledged that while social support must be considered a major component in recovery, a victim’s expression of affect associated with a trauma may actually lead members of support networks to be more rejecting. Indeed, a thorough model of revictimization must not only recognize the cognitive mechanism of
avoidance necessitated by the overwhelm of a traumatic assault (Acierno et al., 1999) but also the part that the enveloping American society plays in keeping the ubiquitous phenomenon of sexual victimization hidden.

Sexual assault is largely an unacknowledged crime by both society at large and by the victim herself. As Kahn and Andreoli Mathie (2000) suggest, given that the lay public may still not be ready to recognize acquaintance assault as a crime, it is not surprising that unacknowledged rape victims, despite an experience that meets the criteria of rape by law, may not consider or label it as such. Indeed, research consistently verifies that of women who are classified as rape victims according to the Sexual Experiences Survey (SES; Koss & Oros, 1982) or other similar behavioral-response instruments, between 43% and 73% respond that they have not been raped when posed the question directly (Andreoli Mathie & Kahn, 1995; Kahn et al., 1994; Koss, 1985; Pitts & Schwartz, 1993). The fact that most women on college campuses are raped by acquaintances (Andreoli Mathie & Kahn, 1995; Gidycz et al., 1993; Kahn et al., 1994) may be an important hint into the inclination of women not to acknowledge an assault, given that the minority of women who are raped by strangers are much more likely to label their experiences as rape (Kahn & Andreoli Mathie, 2000).

Given that women are unlikely to acknowledge that they have been the victims of a crime, it is not surprising that most assaults go unreported (Fisher et al., 2000; Russell, 1983). The recent national survey of college students by Fisher et al. (2000), which found that less than 5% of women who had been the victim of rape or attempted rape reported the crime to law enforcement, sheds light on why women say they are uninclined to report their assaults. When women were asked why they did not report the
incidents to law enforcement, they gave the following reasons: did not know how to report (13.6%), fear of being treated hostilely by police (24.7%), police wouldn’t want to be bothered (25.9%), police wouldn’t think it was serious enough (27.2%), afraid of reprisal by assailant or others (39.5%), lack of proof that incident occurred (42.0%), did not want family to know (44.4%), not clear it was a crime or that harm was intended (44.4%), did not want other people to know (46.9%), and did not think it was serious enough to report (65.4%). Based on these answers, it is clear that women continue to be uninformed, afraid, self-doubting, embarrassed, forgiving, ashamed, and, perhaps most dangerously, in denial about the gravity of the crime perpetrated against them. That is, nearly 2/3 of women who had been the victim of either rape or attempted rape believed that this invasion was not serious enough to report.

What makes a woman believe an invasion of her body is not serious? The answer to this question may reside in the fact that rape often involves an illusory lack of force. That is, by most indications, the predominant nature of rape is hidden, close to home, covertly perpetrated, ambiguous, and, thus, most often unacknowledged. Studies in this domain have found that rape very often does not involve force, but rather, men are more covert – using coercion, ignoring protests, and simply not actively obtaining consent – in achieving intercourse (Muehlenhard & Linton, 1987; Rapaport & Burkhart, 1984). The rape scripts that women hold may play a role as well. For example, in one interesting study, Kahn et al. (1994) found that when asked to write about a typical rape, all but one of the acknowledged rape victims in their sample wrote about an acquaintance rape, whereas 50% of the unacknowledged women wrote about a stranger rape. Perhaps because many women are coerced and ignored prior to being raped, rather
than violently attacked by a stranger with a weapon (a scene women may believe constitutes a *real* rape [Estrich, 1987; Kahn & Andreoli Mathie, 2000]), they believe that their experiences do not meet the level of force required to constitute victimization. Indeed, Bondurant (1995) found that although 62% of women who experienced physical force during their rape acknowledged that assault, less than 10% of women who were intoxicated or were only threatened with force acknowledged that they were raped.

In a study conducted by Andreoli Mathie and Kahn (1995), participants were asked to indicate on a 6-point scale the extent to which a man used various types of pressure, harm, and other aggressive methods during their assaults as well as the forms of resistance the victims had used. Interestingly, for all forms of aggression – including threatening physical harm, covering the victim’s mouth, twisting her body, pushing or shoving, scratching, slapping, hitting, kicking, biting, choking, threatening to use a weapon, or actually using a weapon – women, both acknowledged and unacknowledged, estimated the assailant’s use of force between 0 and 1, indicating that he hardly had used such force at all. The only force items with higher means than 3.0 were verbal pressure (for both acknowledged and unacknowledged victims) and holding the woman down (for acknowledged victims only). Moreover, the only resistance items with means greater than 3.0 – for both acknowledged and unacknowledged victims – were attempting to talk the assailant out of it and verbally protesting. Between 80% and 100% of the women responded “not at all” to having used each of the following resistance strategies: trying to scream but being unable to, screaming or shouting, verbally attacking or swearing, pushing or shoving, scratching, slapping, hitting or
punching, kicking, biting, and trying to use a weapon (Andreoli Mathie & Kahn, 1995). This study brings to light the nature of much acquaintance sexual victimization: it is furtively perpetrated and politely resisted. Moreover, perpetrators may use this lack of evident force in acquaintance assaults to clear their consciences. Indeed, Koss (1988) reported that most men whose behavior meets the legal definition of rape are adamant that their behavior definitely has not constituted rape. As Johnson (1980) has said, “the locus of violence rests squarely in the middle of what our culture defines as ‘normal’ interaction between men and women” (p. 146).

In general, research has shown that women who seek help from rape agencies may be more likely to experience the reactions indicative of posttraumatic stress disorder, including distress, fear, anxiety, depression, lower self-esteem, and self-blame (Frazier, 1990; Janoff-Bulman, 1979; Janoff-Bulman & Timko, 1987; Koss, 1993; Koss & Burkhart, 1989; Rothbaum et al., 1992). Moreover, those who seek help from social service centers are more likely to acknowledge their rapes (Pitts & Schwartz, 1993). It may be posited, then, that severe emotional reactions may lead to help seeking and, thus, acknowledgement by the victim. Kahn and Andreoli Mathie (2000) caution, however, that such a conclusion may be confounded both by the fact that victims of stranger rape are more likely to seek help and by the fact that victims of stranger rape may have actually experienced a more violent rape, may have more severe symptoms, and, thus, may more readily apply the label of rape to their experience (or, vice versa, they may experience more symptoms because of the label they have applied). Again, we are reminded that the posttraumatic symptoms most often investigated tend to be those
that are overtly evidenced, and, in this way, acknowledgement has yet to be purely investigated with avoidance and dissociation in mind.

While victims may in fact differ on degree of general affective symptomatology according to whether or not they are acknowledged, self-blame is common for all victims and does not discriminate based on acknowledgement (Andreoli Mathie & Kahn, 1995). Furthermore, self-blame may have a major impact on the way women conceptualize their experiences, since, according to Katz and Burt (1988), self-blame is correlated with longer recovery, greater suicidality, and lower self-esteem. Moreover, the blow of rape to self-esteem may extend for well over 2 years (Marhoefer-Dvorak, Resick, Hutter, & Girelli, 1988; Murphy et al., 1988; Resick, 1993) and arguably is perpetuated by society. That is, when considering the possibility of whether to pursue her victimization in the courts, a woman will likely be told by the court that her case is unfounded and that it will, more likely than not, either be dropped or plea-bargained (Bohmer, 1998). Bohmer points out that especially in cases of acquaintance rape, “[the legal process] is a vast funnel that gets narrower as fewer and fewer cases are retained” (1998, p. 259).

Indeed, other studies have suggested that substantial attrition of sexual assault cases exists in the legal system, that more severe assaults constitute those that are prosecuted, and that victims are generally not satisfied with the legal process (e.g., Frazier & Haney, 1996). Preliminary investigation suggests that this type of avoidance by society as a whole can inhibit a woman’s own acknowledgement of victimization, given one study, for example, in which both acknowledged and unacknowledged victims – asked if they had told a friend about the experience and, if so, if the friend had
helped the individual place blame – found that it often took friends stating that the incident was not the victim’s fault for the victim to acknowledge it as an assault (Pitts & Schwartz, 1993). With a legal system so unwelcoming of hearing women’s stories, it is not surprising that women look inward, instead of outward at the perpetrator, in placing blame for victimization.

Given the historical record of the criminal justice system, it is also not surprising that women have traditionally avoided reporting and prosecuting the sexual crimes committed against them (Bohmer, 1998; Donat & D’Emilio, 1998; LaFree, 1989). Seventeen states require adult rape victims, and 11 require child victims, to be polygraphed prior to accepting charges for prosecution, and only 7.5% of reported rapes in Philadelphia, for example, reach a guilty verdict (Koss, 2001). In the not so distant past, many states’ sexual assault laws permitted or required that questions such as vaginal penetration, resistance by the victim, and woman’s sexual past be used as evidentiary issues at trial (Berger, Searles, & Neuman, 1988; Bohmer, 1998; Donat & D’Emilio, 1998). That is, the woman’s behavior was in question and her past was automatically suspect. Over the past 20 years, rape law reform has focused on revising these problems (e.g., the requirements that a woman be raped vaginally, resist, or reveal her sexual history [evidence of which is still permitted in civil cases]; Bohmer, 1998). Also, the law has shifted toward downplaying the evidentiary question of a woman’s consent (which, because of the he said/she said problem is obviously difficult to prove), and, rather, makes the issue of force or threat of force used by the man the central question of rape trials (Bohmer, 1998).
As previously discussed, however, overt use of force is not the reality of most instances of sexual victimization by an acquaintance (e.g., Andreoli Mathie & Kahn, 1995; Estrich, 1987). Not surprisingly, given the discrepancy between the actual nature of assaults and those that tend to succeed at trial, only 9% of acquaintance perpetrators on trial in Washington D.C. are convicted (Koss, 2001). Thus, while rape law reform has attempted to acknowledge coercion by including various gradations of sexual assault – first-, second-, and third-degree offenses – these efforts to convey the spirit of the real picture of rape to the courtroom seem to be unsuccessful (Berger et al., 1988; Bohmer, 1998). Few studies have shown any resultant increases in arrest rates or in the percentage of reported rapes resulting in conviction as a result of rape law reform (Loh, 1980, 1981; Polk, 1985).

While it has already been established that “the anti-rape movement must not limit itself to training women to avoid rape…but must aim its attention at changing the behavior and attitudes of men” (Hall, 1983, p. 346), the movement must also recognize that public policy is critical to making change and that merely encouraging men to change their 20-year old ideas of sex roles might not be radical enough to move anything at all. The problem of consent is unquestionably a difficult issue to tackle objectively in the courts (MacKinnon, 1983), and, as discussed, the victim faces an “uphill battle” in this regard (Bohmer, 1998, p. 252). However, before the issue of consent is eradicated from the law for good, it is important to consider that the law has yet to define with clarity what consent means. A man can get away with not considering his behavior as rape (Bohmer, 1998; Koss, 1988), because cultural attitudes do not allow for sexual uncertainty on the part of a woman (Bohmer, 1998). Because of this,
men can use coercive means (Muehlenhard & Linton, 1987; Rapaport & Burkhart, 1984) to obtain sex. Perpetuating the notion that the victim is somewhat to blame for the coerced sex that is born of these situations, the law attributes comparative fault in cases of rape (Bublick, 1999).

The Present Study

Given the prevalence of unacknowledged and unreported acquaintance assault and of revictimization, the question is begged whether avoidant response to sexual assault is yet thoroughly understood in terms of its effects on cognitive resolution. Addressing this concern, McCann et al. (1988) cautions that the prevalence of PTSD may be underestimated because persons with avoidant posttraumatic symptomatology, as opposed to either reexperiencing- or mixed-type responses, may not be readily identifiable. Thus, given that avoidant-type responses to trauma are likely underestimated, it is possible that there exists a yet unexplored subgroup of victims at even greater risk for repeated victimization. Indeed, Koss has remarked, “the trauma research community…decontextualizes rape…[creating an] incomplete capture of the ways in which rape creates harm,” and, further, rape constitutes a unique social trauma, “because of…the influence of gender and culture on lay views of what causes rape, and the influence of these factors on the recovery environment a rape survivor faces” (2000, p. 11).

Peritraumatic dissociation as a predictor of posttraumatic symptomatology has scarcely been applied to the field of sexual assault, and prior to Pashdag et al. (1999), it had never been considered prospectively as a potential predictor of revictimization. Yet, the literature to date that has looked at peritraumatic dissociation and sexual assault
does seem to suggest, as might be expected, that assault survivors who engage in peritraumatic dissociation are, like other victims of trauma, particularly vulnerable to subsequent posttraumatic stress symptoms and dissociation. In the Griffin et al. (1997) study, 94% of individuals in the high peritraumatic dissociation group were identified as meeting PTSD symptom criteria. Perhaps even more telling than this finding, however, was that the high peritraumatic dissociation group differed from the low peritraumatic dissociation group in physiological indicators, particularly in that they suppressed autonomic arousal. Based on these findings, the authors proposed a subtype of persons with PTSD who chronically engage in dissociative mechanisms and who, thus, fail to cognitively and emotionally process trauma (Griffin et al., 1997).

Epstein (1989, 1993) has described the self-cloaking nature of avoidant symptoms that he suggests likely leads to the underestimation of avoidant persons in the general diagnosis of PTSD. Epstein (1993) recommends using avoidance items from the IES to detect this tendency toward hidden avoidance symptoms. Moreover, a recent study with burn survivors found that avoidant behavior as measured by the IES was better at predicting intrusive symptoms at 4-month follow-up than were initial intrusive symptoms; the authors concluded, “avoidant behavior played an important role in the maintenance if not the exacerbation of intrusive thoughts…[and this role] should be explored…with a variety of stressors such as rape” (Lawrence et al., 1996). Combining these sentiments, the present study will endeavor to determine whether peritraumatic dissociation in victims of sexual assault can be conceptualized as a marker for those who will proceed to develop an avoidant cognitive strategy. In this way, Griffin et al. ’s (1997) mandate, “the link between dissociation and general avoidance of the trauma
deserves further study” (p. 1086), will be addressed. Certainly, if this experiential marker could be identified in victims immediately following the trauma, clinicians might be better able to predict dissociation among certain individuals during therapy and could more appropriately engage these clients in exposure-based interventions (Johnson et al., 2001).

Griffin et al. (1997) was astute in recognizing that the cognitive strategies of dissociation and avoidance in sexual assault victims, initiated by way of peritraumatic experience, deserve further investigation, and, furthermore, that the potential repercussion of these strategies in terms of revictimization is an important problem to consider. Indeed, given that the relatively young literature on peritraumatic dissociation described thus far indicates that it is predictive of future PTSD and dissociative symptomatology, it is surprising that little has been done to investigate this process in sexual trauma victims. Moreover, investigation into the effects of peritraumatic distress, or emotional reactions other than dissociation at the time of the traumatic event, on subsequent functioning in trauma victims is just at its inception (Brunet et al., 2001) and has never before been looked at in sexual assault victims. Given that dissociative symptomatology and PTSD have been demonstrated to increase the risk that an individual will be revictimized, this course – from peritraumatic dissociation, to lack of resolution, to revictimization – should be explored within an appropriate sociocognitive avoidance framework.

The present study investigated whether the trauma of sexual assault, as manifest by peritraumatic dissociation, and leading to subsequent avoidance and dissociation as well as cognitive discord, would predict increased risk of revictimization. To this end,
601 college women were screened by filling out a questionnaire concerning sexual assault experiences since the age of 14 (see specific eligibility criteria, p. 68). One hundred sixty-seven (27.8%) of these women endorsed the selection criterion of one or more sexual victimization experiences involving vaginal, oral, or anal penetration since the age of 14 according to a modified Sexual Experiences Survey (adolescent version); these women additionally answered questions concerning their dissociative and distress reactions during the experience. Of the 167 eligible participants, 153 (91.6%) women agreed to return 1 week later (and were not subject to exclusion criteria), when they completed additional surveys concerning posttraumatic avoidant and dissociative symptomatology as well as cognitive discord and posttraumatic growth. One-hundred forty-nine of these women (97.4% of those who had participated in the second questionnaire session) then took part in individual interviews about their assault experiences \((M = 8.3 \text{ days post-Screening})\), during which time the PDEQ items were administered in an oral, yes-no interview format.

After approximately 4.2 months \((M = 126.8 \text{ days})\), 144 participants (96.6% of those who had participated in the interview) returned to complete a follow-up survey, during which time they reported on any sexual revictimization experiences that had occurred during the follow-up period. Using a prospective design, this study examined whether unresolved trauma resulting from sexual assault, as indicated by peritraumatic dissociation during the assault, would predict subsequent avoidant and dissociative symptomatology, posttraumatic cognitive discord, and/or lack of posttraumatic growth; and, further, whether these, in turn, would predict revictimization.
Hypotheses

The first hypothesis was that victims of sexual assault who had experienced more peritraumatic dissociation during their assaults would demonstrate more posttraumatic cognitive avoidance and dissociation than those victims who had not experienced the same degree of peritraumatic dissociation.

The second hypothesis was that victims of sexual assault who had experienced more peritraumatic dissociation during their assaults would demonstrate more posttraumatic cognitive discord and less posttraumatic growth than those victims who had not experienced the same degree of peritraumatic dissociation.

The third hypothesis was that victims of sexual assault who had experienced more peritraumatic dissociation, posttraumatic cognitive avoidance, and posttraumatic dissociation were more likely to be revictimized over the course of the study than were victims who had not experienced the same degree of cognitive avoidance and dissociation.

The fourth hypothesis was that sexual assault victims who had experienced more posttraumatic cognitive discord and less posttraumatic growth would be more likely to be revictimized over the course of the study than victims who had not experienced the same degree of posttraumatic discord and lack of posttraumatic growth.

By answering the proposed questions, a subset of women posited to cognitively avoid their traumatic sexual experiences were explored as particularly at risk for revictimization.
Methodology

Participants

Participants in this study were 601 college women at Ohio University who were enrolled in psychology courses and who had the choice to either volunteer in psychology experiments or turn in an alternative assignment. Women were recruited and volunteered by signing up on the general psychology department research board, and volunteer bias was reduced by titling the experiment, “Women’s Social Experiences.” Participants were recruited from September 2001 through January 2002.

Most women who were eligible for the study (see p. 68 for eligibility criteria; \( N = 167 \)) were 18-19 years old (82.0%), in their first or second years of college (88.1%), Caucasian (96.4%), heterosexual (99.4%), never married (97.6%), and either dated casually or were in long-term monogamous relationships (93.4%). These 167 eligible women differed from the 434 non-eligible women in that eligible women (88.0%) were more likely to have willingly engaged in sexual intercourse than non-eligible women (60.4%), \( \chi^2 (1) = 42.42, p < .001 \); eligible women were older at age of first willing sexual intercourse than non-eligible women, \( t (598) = 4.02, p < .001 \); eligible women had had more consensual sexual partners than non-eligible women, \( t (599) = 9.22, p < .001 \); and, compared to non-eligible women, eligible women drank alcohol more often, \( t (599) = 2.81, p < .01 \), drank more on a typical drinking occasion, \( t (598) = 4.95, p < .001 \), and drank to the point of intoxication more often during the prior 2 months, \( t (599) = 3.43, p = .001 \). Demographic data for the eligible women are summarized in Table 1.
Table 1

*Participant Demographics (N = 167)*

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 18</td>
<td>82</td>
<td>49.1</td>
</tr>
<tr>
<td>(b) 19</td>
<td>55</td>
<td>32.9</td>
</tr>
<tr>
<td>(c) 20</td>
<td>21</td>
<td>12.6</td>
</tr>
<tr>
<td>(d) 21</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>(e) 22</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>(f) over 22</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Year in School</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Freshman</td>
<td>109</td>
<td>65.3</td>
</tr>
<tr>
<td>(b) Sophomore</td>
<td>38</td>
<td>22.8</td>
</tr>
<tr>
<td>(c) Junior</td>
<td>13</td>
<td>7.8</td>
</tr>
<tr>
<td>(d) Senior</td>
<td>6</td>
<td>3.6</td>
</tr>
<tr>
<td>(e) Graduate</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Caucasian, non-Hispanic</td>
<td>161</td>
<td>96.4</td>
</tr>
<tr>
<td>(b) African-American</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>(c) Asian/Pacific Islander</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>(d) Hispanic</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>Religion</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Catholic</td>
<td>64</td>
<td>38.3</td>
</tr>
<tr>
<td>(b) Protestant</td>
<td>35</td>
<td>21.0</td>
</tr>
<tr>
<td>(c) Jewish</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>(d) Nondenominational</td>
<td>14</td>
<td>8.4</td>
</tr>
<tr>
<td>(e) None</td>
<td>24</td>
<td>14.4</td>
</tr>
<tr>
<td>(f) Other</td>
<td>26</td>
<td>15.6</td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Heterosexual</td>
<td>166</td>
<td>99.4</td>
</tr>
<tr>
<td>(b) Bisexual</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>(c) Homosexual</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
Table 1: continued.

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marital Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Never married</td>
<td>163</td>
<td>97.6</td>
</tr>
<tr>
<td>(b) Cohabitating</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>(c) Married</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Dating Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Do not date</td>
<td>6</td>
<td>3.6</td>
</tr>
<tr>
<td>(b) Date casually</td>
<td>93</td>
<td>55.7</td>
</tr>
<tr>
<td>(c) Long-term monogamous relation</td>
<td>63</td>
<td>37.7</td>
</tr>
<tr>
<td>(d) Engaged</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td>(e) Married</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td><strong>Willing Sexual Intercourse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Yes</td>
<td>147</td>
<td>88.0</td>
</tr>
<tr>
<td>(b) No</td>
<td>20</td>
<td>12.0</td>
</tr>
<tr>
<td><strong>Age of First Willing Sexual Intercourse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Does not apply/Never willing intercourse</td>
<td>19</td>
<td>11.4</td>
</tr>
<tr>
<td>(b) 13 years or younger</td>
<td>3</td>
<td>1.8</td>
</tr>
<tr>
<td>(c) 14 years</td>
<td>18</td>
<td>10.8</td>
</tr>
<tr>
<td>(d) 15 years</td>
<td>24</td>
<td>14.4</td>
</tr>
<tr>
<td>(e) 16 years</td>
<td>42</td>
<td>25.1</td>
</tr>
<tr>
<td>(f) 17 years</td>
<td>31</td>
<td>18.6</td>
</tr>
<tr>
<td>(g) 18 years</td>
<td>22</td>
<td>13.2</td>
</tr>
<tr>
<td>(h) 19 years or older</td>
<td>7</td>
<td>4.2</td>
</tr>
<tr>
<td>(i) Missing value</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Number of Consensual Sex Partners</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 0</td>
<td>22</td>
<td>13.2</td>
</tr>
<tr>
<td>(b) 1</td>
<td>32</td>
<td>19.2</td>
</tr>
<tr>
<td>(c) 2</td>
<td>25</td>
<td>15.0</td>
</tr>
<tr>
<td>(d) 3</td>
<td>25</td>
<td>15.0</td>
</tr>
<tr>
<td>(e) 4</td>
<td>15</td>
<td>9.0</td>
</tr>
<tr>
<td>(f) 5</td>
<td>13</td>
<td>7.8</td>
</tr>
<tr>
<td>(g) 6</td>
<td>12</td>
<td>7.2</td>
</tr>
<tr>
<td>(h) 7 or more</td>
<td>23</td>
<td>13.8</td>
</tr>
</tbody>
</table>
Table 1: continued.

<table>
<thead>
<tr>
<th>Frequency of Alcohol Consumption</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Never drink or not during past year</td>
<td>8</td>
<td>4.8</td>
</tr>
<tr>
<td>(b) Less than once per month, at least once in the past year</td>
<td>16</td>
<td>9.6</td>
</tr>
<tr>
<td>(c) 1-3 times per month</td>
<td>48</td>
<td>28.7</td>
</tr>
<tr>
<td>(d) 1-2 times per week</td>
<td>65</td>
<td>38.9</td>
</tr>
<tr>
<td>(e) More than twice per week</td>
<td>30</td>
<td>18.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Alcohol Consumption During Typical Drinking Occasion</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) None</td>
<td>8</td>
<td>4.8</td>
</tr>
<tr>
<td>(b) No more than 3 beers (or 2 wine/spirits)</td>
<td>21</td>
<td>12.6</td>
</tr>
<tr>
<td>(c) No more than 4 beers (or 3 wine/spirits)</td>
<td>29</td>
<td>17.4</td>
</tr>
<tr>
<td>(d) No more than 5-6 beers (or 4 wine/spirits)</td>
<td>65</td>
<td>38.9</td>
</tr>
<tr>
<td>(e) No more than 6 beers (or 5 wine/spirits)</td>
<td>43</td>
<td>25.7</td>
</tr>
<tr>
<td>(f) Missing value</td>
<td>1</td>
<td>0.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Incidence of Intoxication/Drunkenness During Last 2 Months</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Never drink to drunkenness</td>
<td>26</td>
<td>15.6</td>
</tr>
<tr>
<td>(b) 1-3 times</td>
<td>51</td>
<td>30.5</td>
</tr>
<tr>
<td>(c) 4-5 times</td>
<td>30</td>
<td>18.0</td>
</tr>
<tr>
<td>(d) 6-10 times</td>
<td>25</td>
<td>15.0</td>
</tr>
<tr>
<td>(e) 11-15 times</td>
<td>22</td>
<td>13.2</td>
</tr>
<tr>
<td>(f) 16-20 times</td>
<td>10</td>
<td>6.0</td>
</tr>
<tr>
<td>(g) 21-25 times</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>(h) More than 25 times</td>
<td>3</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Excluded Women and Attrition Rates

Exclusion criteria for the study included current suicidal ideation, a history of psychiatric hospitalization, and current treatment for a serious psychiatric condition. Of 167 eligible women, three (1.8%) were excluded for current suicidal ideation.
Of the remaining 164 women, seven (4.3%) declined participation in the next phase of the study for various reasons (e.g., did not need additional research credits, not interested in participating), and four women (2.4%) were unreachable. Thus, 153 of the 164 eligible, non-excluded women (93.3%) participated in the second questionnaire session, scheduled, on average, 1 week after the initial screening.

Of the 153 women who participated in the second questionnaire session, three (2.0%) declined participation in the interview, and one woman (0.7%) did not show. Thus, 149 of the 153 women (97.4%) who had participated in the second questionnaire session also participated in the interview, scheduled, on average, 8.3 days following the initial screening.

Of the 149 women who participated in the interview, one woman (0.7%) did not return her follow-up questionnaire by mail, two women (1.3%) were unavailable, and two women (1.3%) did not show for the final follow-up session. Thus, 144 of the 149 women (96.6%) who had participated in the interview also participated in the follow-up questionnaire session approximately 4.2 months later. Overall attrition from the 164 women who were eligible and were not excluded from the study due to current suicidal ideation included 20 women, a retention rate of 87.8% across all four phases of the 4.2-month long study.

Independent samples t-tests confirmed that women who dropped out of the study did not differ from the women who were retained on any independent or dependent measures. Furthermore, all reported analyses were conducted both with all women who participated at each stage of the study and with only those 144 women who completed
because these analyses yielded identical results, data collected for all women participating at each phase of the study were retained.

**Measures**

*Consent Forms.* Informed Consent Forms were distributed and read aloud with participants prior to their participation at each phase of the study. The principal investigator was available to answer participants’ questions both prior to written consent and throughout each session of the study (see Appendix A).

*Background Questions Form.* This form was completed during the screening session to determine whether participants met any of the study’s exclusion criteria. If women endorsed current suicidal ideation, a history of psychiatric hospitalization, and/or current treatment for a serious psychiatric condition, they were not invited to participate in additional phases of the study (see Appendix B).

*Contact Form.* This form was completed prior to the screening session, to inform women of the processes by which the principal investigator might contact them at future points in the study and to obtain contact information (see Appendix C).

*Demographics Questionnaire.* This brief questionnaire was administered to collect relevant personal information such as age, ethnicity/race, religious background, sexual orientation, drinking habits, and consensual dating behavior (see Appendix D).

*Sexual Experiences Survey.* The Sexual Experiences Survey (SES; Koss & Oros, 1982) is a 10-item self-report instrument that was designed to describe in behavioral terms various degrees of sexual victimization. Typical of the items that reflect extreme forms of victimization is the following: "Have you ever had sexual intercourse when you didn't want to because a man threatened you or used some degree of force –
twisting your arm, holding you down, etc. – to make you?" The test-retest reliability of the instrument at 1 week has been demonstrated to be .93, and the construct validity was demonstrated by a Pearson correlation of .73 between women’s level of victimization reported on the SES and her level of victimization reported during an interview (Koss & Gidycz, 1985). In light of revisions made in a new, yet-unpublished draft of the SES (SES-RV; Koss & Bachar, 2001), original SES items were modified to specify types of assaultive penetration (i.e., vaginal, oral, or anal) for all relevant questions, and a question was added concerning inability to give consent to sex due to drunkenness or being stoned. Also, two questions regarding acknowledgement and reporting were added. Eligibility for the present study and the revictimization criteria were defined according to endorsement of any one of items 6-10 (i.e., experiences ending in completed intercourse), including having been too drunk/stoned to consent, having been overwhelmed by arguments/pressure, having been used by a perpetrator in a position of authority, having been given alcohol/drugs which prevented resistance, and/or having been involved in an assault involving threats or some degree of physical force (see Appendix E).

Peritraumatic Dissociative Experiences Questionnaire – Self-Report Version.
The Peritraumatic Dissociative Experiences Questionnaire – Self-Report Version (PDEQ; Marmar et al., 1997) uses 10 questions to assess the severity of psychological dissociation at the time of a sexual abuse or assault experience. Participants were asked to endorse items such as, “I had moments of losing track of what was going on – I 'blanked out' or 'spaced out' or in some way felt that I was not part of what was going on,” on a 5-point scale, with possible responses ranging from "Not at all true" to
"Extremely true." Several studies have investigated the use of the PDEQ with male and female Vietnam veterans, emergency services workers, and earthquake survivors, and have found the device to be internally consistent and strongly associated with measures of traumatic stress responses, general dissociative tendencies, and level of stress exposure (Marmar, Weiss, Metzler, Ronfeldt, et al., 1996; Marmar et al., 1994; Tichenor et al., 1996; Weiss et al., 1995). For the present analyses, a score was computed by averaging peritraumatic dissociation items, so that participants with missing items could be included (see Appendix F).

**Peritraumatic Distress Inventory.** The Peritraumatic Distress Inventory (PDI; Brunet et al., 2001) uses 13 questions to assess the severity of psychological distress (rather than dissociative responses) at the time of sexual abuse or assault experience. It was formulated based on criterion A2 for PTSD, which requires high levels of distress during or after a traumatic event (APA, 2000). The measure was demonstrated in a cross-sectional study of 702 police officers and 301 matched controls to predict posttraumatic stress symptoms, when controlling for peritraumatic dissociation (Brunet et al., 2001). This initial study demonstrated that the PDI is internally consistent, stable over time, and has good convergent and divergent validity (Brunet et al., 2001). Specifically, the test-retest correlation ($M = 391$ days) was .74, the standardized coefficient alpha for the total PDI score was .75, and the PDI correlated with conceptually similar measures such as peritraumatic dissociation ($r = .47$), the Mississippi scale for PTSD ($r = .46$), and both the avoidance and intrusion subscales of the IES-R (each $r = .47$). Participants were asked to endorse such items as “I felt helpless to do more” and “I felt sadness and grief” on a 5-point scale, with possible
responses ranging form “Not at all true” to “Extremely true.” For the present analyses, a score was computed by averaging peritraumatic distress items, so that participants with missing items could be included (see Appendix G).

Impact of Event Scale - Revised. The Impact of Event Scale - Revised (IES-R; Weiss & Marmar, 1997) uses 22 questions to assess 14 of the 17 DSM-IV symptoms of Post-Traumatic Stress Disorder (PTSD), including subjective experiences of intrusion, avoidance, and hyperarousal resulting from a specific traumatic event. In the Weiss and Marmar study, participants were asked to think about the most stressful event they had ever experienced and to state how often each symptom was true for them over the past 7 days on a 4-point scale, with responses ranging from "Not at all" to "Extremely." Weiss and Marmar found evidence of good internal consistency, including Cronbach's alpha values for subscale scores ranging from .79 to .92 in various samples and 6-month test-retest reliability correlations for subscale scores ranging from .89 to .94. Convergent validity was supported by a correlation of .77 between IES-R score and reexperiencing score on the Posttraumatic Stress Disorder Scale and a correlation of .69 between IES-R score and avoidance cluster score on the Posttraumatic Stress Disorder Scale (see Appendix H).

For the present study, posttraumatic avoidance items were extracted from the IES-R. However, because there is some disagreement in the literature concerning the items that most appropriately contribute to the avoidance subscale (Joseph, 2000), a multi-step procedure was utilized to extract the most appropriate items tapping avoidance for the present sample. First, avoidance items were selected according to their face resemblance to DSM-IV-TR avoidance criteria for PTSD (APA, 2000); these
included the following items (see Appendix H): 5, 7, 8, 11, 12, 13, 17, and 22. Second, an exploratory factor analysis of all IES-R items revealed that each of these items (but not the other IES-R items) loaded onto an avoidance factor, except for item 12, which loaded onto the factor only minimally. Finally, in order to determine whether or not item 12 should be included in the avoidance scale, reliability coefficients were determined for the full group of items (including item 12) and for the reduced group (excluding item 12). Because retaining item 12 minimally increased the reliability of the avoidance item cluster ($\alpha = .82$), it was determined that item 12 would be retained in the avoidance scale. For the present analyses, a score was computed by averaging IES-R avoidance items, so that participants with missing items could be included.

*Dissociative Experiences Scale Revised – Version 2.* The Dissociative Experiences Scale Revised – Version 2 (DES-R-2; Coe, Dalenberg, Aransky, & Reto, 1995) assesses current dissociative experiences; that is, the scale measures dissociation at the present time rather than at the time of the traumatic experience. The scale uses 41 questions to assess how often various dissociative symptoms, including amnesia, depersonalization, derealization, absorption, and imaginative involvement, occur in the participant. Each question is answered on a 6-point scale, with answers ranging from "Never" to "At least once a week." The scale is a revision of the widely used DES (Carlson & Putnam, 1993), on which participants were required to indicate the frequency of 28 different dissociative symptoms by circling a number on an 11-point scale ranging from 0 = "Never" to 100 = "Always.” Alternate form reliability between this scale and the original DES has been shown to be greater than .90 (Coe et al., 1995). A meta-analysis of validity data on the DES demonstrated that the convergent validity
of the instrument is quite good (Cohen’s $d = 1.82$; $N = 5,916$), correlating both with similar questionnaires and with interview measures (van IJzendoorn & Schuengel, 1996). For the present analyses, a score was computed by averaging DES-R-2 items, so that participants with missing items could be included (see Appendix I).

Posttraumatic Cognitions Inventory. The Posttraumatic Cognitions Inventory (PTCI; Foa et al., 1999) is a measure of trauma-related thoughts and beliefs. Participants were asked to answer 36 items regarding their thoughts about a traumatic experience, including such items as “People can’t be trusted,” “The world is a dangerous place,” and “I have no future.” In an initial study, the scale was administered to 601 volunteers, including 392 persons who had experienced a traumatic event and 170 persons who had been diagnosed with moderate to severe posttraumatic stress disorder. Internal consistency was excellent, with a Cronbach's alpha of .97. The test-retest reliabilities (Spearman Rho correlation) were .74 at 1 week and .85 at 3 weeks. Convergent validity was demonstrated by significant Spearman correlations with PTSD severity (.79), depression (.75), and state and trait anxiety (.70 and .75, respectively). For the present analyses, a score was computed by averaging PTCI items, so that participants with missing items could be included (see Appendix J).

Posttraumatic Growth Inventory. The Posttraumatic Growth Inventory (PTGI; Tedeschi & Calhoun, 1996) is a measure of posttraumatic positive change, including the factors New Possibilities, Relating to Others, Personal Strength, Spiritual Change, and Appreciation of Life. Participants were asked to answer 21 items asking what changes have occurred in their lives as a result of the traumatic incident. Each item was answered on a 6-point scale ranging from 1 = “I did not experience this change” to 6 =
“I experienced this change to a very great degree.” The five factors are internally consistent, with alpha equal to .90, and each factor additionally showed good internal consistency: New Possibilities ($\alpha = .84$), Relating to Others ($\alpha = .85$), Personal Strength ($\alpha = .72$), Spiritual Change ($\alpha = .85$), and Appreciation of Life ($\alpha = .67$). The test-retest reliability over 2 months for the 21-item scale was .71. The scale was modestly related to extraversion and optimism (.31 and .34), respectively (Tedeschi & Calhoun, 1996). For the present analyses, a score was computed by averaging PTGI items, so that participants with missing items could be included (see Appendix K).

**Interview.** Participants took part in individual, face-to-face interviews concerning their adolescent sexual assault experiences. Interviews were conducted by the principal investigator, a graduate student in the Department of Psychology, and were audiotaped. The interview was designed to obtain each participant's impromptu narrative of her sexual assault experience. Each participant was asked to describe her most bothersome adolescent sexual assault experience, the impact of this experience on her life, her label for the experience, her reporting behaviors, her degree of upset during the interview, and her reason for participating in the study. All participants were free to choose where to begin and end their answers and how much detail to provide; elaboration was neither encouraged nor discouraged. The interview data was primarily obtained to investigate hypotheses other than the present ones. However, for the purposes of the present analyses, yes-no responses to PDEQ items (described below) were also obtained during the interview (see Appendix L for the complete interview format).
Peritraumatic Dissociative Experiences Questionnaire – Rater Version. The Peritraumatic Dissociative Experiences Questionnaire – Rater Version (Marmar et al., 1997) consists of 10 items that correspond to the items on the PDEQ – Self-Report Version but is designed to be rated by an interviewer on a scale ranging from 01 = Absent or False to 03 = Threshold, with DK = Don’t know. Across several studies, the PDEQ has been found to be internally consistent, strongly associated with measures of traumatic stress, and unassociated with general psychopathology. During the interview session of the present study, the 10 questions were asked in a yes-no format after interview question number two. Included were questions such as, “Did you have moments of losing track of what was going on – that is, did you ‘blank out’ or ‘space out’ or in some way feel that you were not part of what was going on?” and “Did you find that you were on ‘automatic pilot’ – that is, did you end up doing things that you later realized that you hadn’t actively decided to do?” The presence or absence of each item was noted, with Absence = 0 and Presence = 1. A score was computed by averaging the responses of PDEQ-interview items, so that participants with missing items could be included.

Debriefing Forms. Debriefing Forms were distributed to each participant following every phase of the study. These forms provided information concerning the purpose of the study as well as contact and referral information (see Appendix M).

Procedure

Questionnaire sessions were held in small classrooms in the Department of Psychology. The principal investigator was available for participants during every phase
of data collection. Figure 1 depicts the time line for all four phases of the study, as well as the instruments utilized at each phase.

Participation involved approximately 0.5-1 hour for the Screening Session, and participants received one psychology credit for their participation. The second questionnaire session ($M = 1$ week follow-up) took approximately 1 hour, and participants received two credits for their participation (Session I). Interviews ($M = 8.3$-day follow-up) were scheduled for 30-minutes, and actual interview times varied in length. The final questionnaire session ($M = 4.2$-month follow-up) involved approximately 1 hour, and participants were paid $20 for their participation (Session II).

At the beginning of the Screening Session, the principal investigator distributed participant identification numbers and questionnaire packets, along with the Consent Form (Appendix A), the Background Questions Form (Appendix B), and the Contact Form (Appendix C) attached to the front. The Consent Form was read aloud, and it was explained that identification numbers would be used to identify and track participants’ data across the study and that these numbers would be catalogued on a master list. This master list was kept in a locked file cabinet in a locked office until each subsequent part of the study. After participants had consented to participation and had completed the Background Questions Form and Contact Form, the principal investigator asked participants to open an envelope containing the questionnaire packet and scantron forms. The questionnaire packet included the Demographics Questionnaire, the Sexual Experiences Survey (adolescent version), the PDEQ (if victimized), the PDI (if victimized), and a filler survey for nonvictims concerning legal evaluations of ambiguous sexual assault scenarios. After completing all questionnaires, participants
Figure 1. *Study Time Line and Instruments Utilized at Each Phase*

<table>
<thead>
<tr>
<th>Phase of Study</th>
<th>Time from Beginning Study</th>
<th>Instruments Utilized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening (<em>N</em> = 601)</td>
<td></td>
<td>Consent Form, Background Questions Form, Contact Form, Demographics Questionnaire, Sexual Experiences Survey (Adolescent Version; SES), Peritraumatic Dissociative Experiences Questionnaire (PDEQ), Peritraumatic Distress Inventory (PDI), Debriefing Form</td>
</tr>
<tr>
<td>Session 1 (Second Questionnaire Session; <em>N</em> = 157)</td>
<td><em>M</em> = 1 week</td>
<td>Consent Form, Impact of Event Scale-Revised (IES-R), Posttraumatic Cognitions Inventory (PTCI), Posttraumatic Growth Inventory (PTGI), Dissociative Experiences Scale Revised – Version 2 (DES-R-2), Debriefing Form</td>
</tr>
<tr>
<td>Interview (<em>N</em> = 149)</td>
<td><em>M</em> = 8.3 days</td>
<td>Consent Form, Interview Questions (PDEQ items for present analyses), Debriefing Form</td>
</tr>
<tr>
<td>Session 2 (Final Follow-up Questionnaire Session; <em>N</em> = 144)</td>
<td><em>M</em> = 4.2 months</td>
<td>Consent Form, Sexual Experiences Survey (Adult Version; SES), Peritraumatic Dissociative Experiences Questionnaire (PDEQ), Peritraumatic Distress Inventory (PDI), Impact of Event Scale-Revised (IES-R), Posttraumatic Cognitions Inventory (PTCI), Posttraumatic Growth Inventory (PTGI), Dissociative Experiences Scale Revised – Version 2 (DES-R-2), Debriefing Form</td>
</tr>
</tbody>
</table>
were given a debriefing statement, credit for participation, and were reminded that they might be contacted within the next few days to participate in additional parts of the study.

Following this session, the principal investigator contacted eligible participants by telephone and invited them to participate in the remaining portions of the study. Furthermore, participants ($N = 30$) who had endorsed recent thoughts of self-harm were contacted by the principal investigator, who conducted suicide risk assessments and offered referral information over the phone. Three eligible women endorsed current suicidal ideation over the telephone, and these women were not invited to participate in the remainder of the study. Risk assessments were documented in writing by the principal investigator and were reviewed by her advisor, a licensed psychologist in the Department of Psychology.

During the 1-week follow-up questionnaire session (Session I), consent information was read aloud to participants. After all participants had read and signed their consent forms, they were provided their subject numbers and were instructed to record them on their scantron forms. They then completed the questionnaire packet, including the IES-R, the PTCI, the PTGI, and the DES-R-2. After completing the questionnaires, participants were debriefed, given credit, and signed up for subsequent interviews.

Interviews were conducted individually in the Ohio University Psychology and Social Work Clinic, unless a participant required an after-hours interview, in which case the interview was conducted in a private office in the Department of Psychology. All 149 interviews were conducted by the principal investigator and were scheduled soon
after participation in Session I (i.e., $M = 8.3$ days post-Screening). Interviews were recorded on audiotape with participants’ consent, and women were identified only by their subject numbers. The interview consisted of the questions described in Appendix L, including 10 PDEQ items. Following the interviews, participants were debriefed, received credit, and were reminded that they would be contacted in approximately 4 months to be scheduled to participate in Session II, the final follow-up questionnaire session.

Women who experienced distress during their interviews were allowed time during which the interviewer assessed whether the participant wished to stop the interview. Only one woman wished to discontinue her interview, stating that she had not realized that it would be so difficult for her. This woman, like all women who showed any sign of distress, was thoroughly debriefed and was offered references for therapeutic intervention. Although no women were interested in intervention, every participant who was interviewed received referral information on the Debriefing Form given to her and was invited to contact the principal investigator for any additional information or guidance. One woman contacted the principal investigator after she had completed the study for unrelated reasons, and a therapy referral was made.

At the final questionnaire session, (Session II; 4.2-month follow-up), each participant was given her subject number and was instructed to record it on her scantron forms. Participants again read and signed an Informed Consent Form, and, subsequently, completed the SES (this time, the adult version), which asked about sexual experiences since the Screening. Additionally, participants completed the PDEQ, PDI, IES-R, PTCI, PTGI, DES-R-2, and a questionnaire involving legality ratings for
ambiguous sexual assault scenarios. At the conclusion of Session II, participants were debriefed, paid, and thanked for their participation.

Results

Frequency of Sexual Aggression in Overall Sample

A modified version of the Sexual Experiences Survey (Koss & Oros, 1982) was administered to a total of 601 women at the Screening Session. Women were eligible for the present study if they endorsed one or more sexual victimization experiences involving vaginal, oral, or anal penetration since the age of 14 (SES items 6-10; see p. 68 for eligibility criteria). Of these 601 women, 276 women (45.9%) endorsed a history of at least one sexual victimization experience involving unwanted sex play, attempted intercourse, or unwanted intercourse since the age of 14. One-hundred sixty-seven women (27.8%) endorsed at least one sexual victimization experience involving vaginal, oral, or anal penetration since the age of 14, qualifying them under the study’s eligibility criteria (see p. 68). Table 2 summarizes the frequencies of the highest level of sexual victimization since the age of 14 endorsed by the sample of women who were screened.

Victims’ Descriptions of Adolescent Sexual Assault Experiences

Table 3 summarizes the way that eligible women (i.e., those who had endorsed at least one sexual victimization experience involving vaginal, oral, or anal penetrations since the age of 14; see p. 68 for specific criteria) characterized their adolescent sexual assault experience(s). The majority of victimizations had involved one man (92.8%), perpetration by an acquaintance (96.9%), and had occurred 6 months or more prior to the study (65.9%). Very few women believed that they had been victims of an illegal
Table 2

*History of Highest Level of Sexual Victimization Since the Age of 14 at Screening (N = 601)*

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Reported Victimization</td>
<td>325</td>
<td>54.1</td>
</tr>
<tr>
<td>Unwanted Sex Play: Arguments/Pressure</td>
<td>80</td>
<td>13.3</td>
</tr>
<tr>
<td>Unwanted Sex Play: Authority Figure</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Unwanted Sex Play: Threatened or Physical Force</td>
<td>7</td>
<td>1.2</td>
</tr>
<tr>
<td>Attempted Intercourse: Threatened or Physical Force</td>
<td>9</td>
<td>1.5</td>
</tr>
<tr>
<td>Attempted Intercourse: Alcohol/Drugs Prevented Resistance</td>
<td>11</td>
<td>1.8</td>
</tr>
<tr>
<td>Unwanted Intercourse: Drunk/Stoned and Unable to Consent</td>
<td>39</td>
<td>6.5</td>
</tr>
<tr>
<td>Unwanted Intercourse: Arguments/Pressure</td>
<td>90</td>
<td>15.0</td>
</tr>
<tr>
<td>Unwanted Intercourse: Authority Figure</td>
<td>2</td>
<td>0.3</td>
</tr>
<tr>
<td>Unwanted Intercourse: Alcohol/Drugs Prevented Resistance</td>
<td>14</td>
<td>2.3</td>
</tr>
<tr>
<td>Unwanted Intercourse: Threatened or Physical Force</td>
<td>22</td>
<td>3.7</td>
</tr>
</tbody>
</table>
## Table 3

*Victims’ Descriptions of Adolescent Sexual Assault Experiences (N = 167)*

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Men Involved</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 1 man</td>
<td>155</td>
<td>92.8</td>
</tr>
<tr>
<td>(b) 2 men</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>(c) 3 or more men</td>
<td>8</td>
<td>4.8</td>
</tr>
<tr>
<td><strong>How Well Knew Man/Men</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Didn’t know at all</td>
<td>5</td>
<td>3.0</td>
</tr>
<tr>
<td>(b) Slightly acquainted</td>
<td>28</td>
<td>16.8</td>
</tr>
<tr>
<td>(c) Moderately acquainted</td>
<td>43</td>
<td>25.7</td>
</tr>
<tr>
<td>(d) Very well acquainted</td>
<td>47</td>
<td>28.1</td>
</tr>
<tr>
<td>(e) Extremely well acquainted</td>
<td>44</td>
<td>26.3</td>
</tr>
<tr>
<td><strong>Number of Times He/They Have Done This to You</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) 1</td>
<td>97</td>
<td>58.1</td>
</tr>
<tr>
<td>(b) 2</td>
<td>36</td>
<td>21.6</td>
</tr>
<tr>
<td>(c) 3</td>
<td>11</td>
<td>6.6</td>
</tr>
<tr>
<td>(d) 4</td>
<td>6</td>
<td>3.6</td>
</tr>
<tr>
<td>(e) 5 or more</td>
<td>17</td>
<td>10.2</td>
</tr>
<tr>
<td><strong>How Long Ago It Happened</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Less than three month ago</td>
<td>25</td>
<td>15.0</td>
</tr>
<tr>
<td>(b) 3-6 months ago</td>
<td>32</td>
<td>19.2</td>
</tr>
<tr>
<td>(c) 6 months-1 year ago</td>
<td>31</td>
<td>18.6</td>
</tr>
<tr>
<td>(d) 1-2 years ago</td>
<td>44</td>
<td>26.3</td>
</tr>
<tr>
<td>(e) 3-5 years ago</td>
<td>33</td>
<td>19.8</td>
</tr>
<tr>
<td>(f) Over 5 years ago</td>
<td>2</td>
<td>1.2</td>
</tr>
<tr>
<td><strong>How You Describe the Situation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(a) Don’t feel I was victimized</td>
<td>68</td>
<td>40.7</td>
</tr>
<tr>
<td>(b) Victim of serious miscommunication</td>
<td>51</td>
<td>30.5</td>
</tr>
<tr>
<td>(c) Victim of sexual coercion</td>
<td>34</td>
<td>20.4</td>
</tr>
<tr>
<td>(d) Victim of an illegal sexual assault or rape</td>
<td>14</td>
<td>8.4</td>
</tr>
</tbody>
</table>

*Table continues*
Table 3: continued.

<table>
<thead>
<tr>
<th>Who Reported To</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Have not told anyone</td>
<td>54</td>
<td>32.3</td>
</tr>
<tr>
<td>(b) Only a close friend or family member</td>
<td>108</td>
<td>64.7</td>
</tr>
<tr>
<td>(c) School, medical, or mental health worker/</td>
<td>4</td>
<td>2.4</td>
</tr>
<tr>
<td>Not police</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Have informed the police</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>(e) Informed the police and pressed charges</td>
<td>0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

sexual assault or rape (8.4%), and only one woman (0.6%) had reported the incident to the police.

Frequency of Revictimization in Eligible Sample

A total of 144 women completed all four phases of the study, including the final questionnaire follow-up ($M = 4.2$ months), during which time they reported on any revictimization experiences that had occurred during the follow-up period. During this time, 53 women (36.8%) endorsed having experienced at least one sexual revictimization incident involving unwanted sex play, attempted intercourse, or unwanted intercourse. Forty of the 144 women who completed the study (27.8%) endorsed at least one sexual revictimization experience involving vaginal, oral, or anal penetration during the follow-up period, qualifying them under the sexual revictimization criterion for this study. Table 4 summarizes the frequencies of the highest level of sexual revictimization during the 4.2-month follow-up period for those women who completed every phase of the study.
Table 4

Frequency of Revictimization After 4.2 Months in Eligible Sample (N = 144)

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Reported Revictimization</td>
<td>91</td>
<td>63.2</td>
</tr>
<tr>
<td>Unwanted Sex Play: Arguments/Pressure</td>
<td>9</td>
<td>6.3</td>
</tr>
<tr>
<td>Unwanted Sex Play: Authority Figure</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Unwanted Sex Play: Threatened or Physical Force</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Attempted Intercourse: Threatened or Physical Force</td>
<td>2</td>
<td>1.4</td>
</tr>
<tr>
<td>Attempted Intercourse: Alcohol/Drugs Prevented Resistance</td>
<td>1</td>
<td>0.7</td>
</tr>
<tr>
<td>Unwanted Intercourse: Drunk/Stoned and Unable to Consent</td>
<td>7</td>
<td>4.9</td>
</tr>
<tr>
<td>Unwanted Intercourse: Arguments/Pressure</td>
<td>23</td>
<td>16.0</td>
</tr>
<tr>
<td>Unwanted Intercourse: Authority Figure</td>
<td>0</td>
<td>0.0</td>
</tr>
<tr>
<td>Unwanted Intercourse: Alcohol/Drugs Prevented Resistance</td>
<td>8</td>
<td>5.6</td>
</tr>
<tr>
<td>Unwanted Intercourse: Threatened or Physical Force</td>
<td>2</td>
<td>1.4</td>
</tr>
</tbody>
</table>
Linear Regression Analyses Examining Posttraumatic Sequelae of Peritraumatic Dissociation

Table 5 describes the constructs that were analyzed, along with their respective measurement instruments, in evaluating posttraumatic avoidant and dissociative symptoms hypothesized to be associated with peritraumatic dissociation. Linear regression was used to determine the strength of association between peritraumatic dissociation and each posttraumatic outcome (see Figure 2).

Table 5

Linear Regression Model: Constructs and Measures Utilized

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure</th>
<th>Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peritraumatic Dissociation</strong></td>
<td>Peritraumatic Dissociative Experiences Questionnaire (PDEQ)</td>
<td>continuous</td>
</tr>
<tr>
<td><strong>Posttraumatic Cognitive Avoidance</strong></td>
<td>Dissociative Experiences Scale Revised – Version 2 (DES–R–2)</td>
<td>continuous</td>
</tr>
<tr>
<td>Dissociation</td>
<td>Impact of Event Scale – Revised (avoidance subscale) (IES-R)</td>
<td>continuous</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Posttraumatic Cognitions Inventory (PTCI)</td>
<td>continuous</td>
</tr>
<tr>
<td>(Lack of) Growth</td>
<td>Posttraumatic Growth Inventory (PTGI)</td>
<td>continuous</td>
</tr>
</tbody>
</table>
Figure 2. Linear Regression Model: Relationship Between Peritraumatic Dissociation and Cognitive Outcome Variables

Peritraumatic Dissociation (PDEQ)

- Avoidance (IES-R)
- Dissociation (DES-R-2)
- Cognitive Discord (PTCI)
- Lack of Positive Growth (PTGI)
Indicators of avoidant-type cognitive disposition (as predicted by PDEQ score) were posited to include the following: 1. posttraumatic cognitive avoidance (as measured by IES-R avoidance items; preceded by Epstein [1993] and Lawrence et al. [1996]); 2. posttraumatic dissociative symptomatology (as measured by DES-R-2 score; preceded by Bremner et al. [1992] and Tichenor et al. [1996]); 3. disrupted posttraumatic cognitions (measured by PTCI score; as theorized, among others, by Horowitz [1986], Janoff-Bulman & Frieze [1983], and McCann & Pearlman [1990]; and, 4. lack of posttraumatic growth (measured by PTGI score; as theorized by Janoff-Bulman [1979]). In summary, the relationship between peritraumatic dissociation (PDEQ; Marmar et al., 1997) and cognitive outcome was expected to be positive for posttraumatic avoidance, dissociation, and cognitive discord, and negative for posttraumatic growth.

As hypothesized, a positive, significant relationship was found when PDEQ score was independently regressed onto IES-R avoidance score, \( B = .475, p < .001 \), DES-R-2 score, \( B = .371, p < .001 \), and PTCI score, \( B = .386, p < .001 \). That is, women who reported greater levels of dissociation during their adolescent sexual assault experiences reported greater posttraumatic levels of avoidance, dissociation, and disrupted cognitions. However, contrary to the prediction that peritraumatic dissociation would inhibit posttraumatic growth, a positive, significant relationship was also found when PDEQ score was independently regressed onto PTGI score, \( B = .242, p < .01 \). These same trends held when the PDEQ score obtained during the interview replaced the PDEQ self-report score, although the relationship using the interview score appeared to be even stronger. That is, positive, significant relationships were found
between PDEQ-interview score and IES-R avoidance score, $B = .549$, $p < .001$, DES-R-2 score, $B = .425$, $p < .001$, PTCI score, $B = .387$, $p < .001$, and PTGI score, $B = .292$, $p < .001$.

In addition to testing the primary hypotheses, peritraumatic distress score (PDI; Brunet et al., 2001) was entered into the model in place of PDEQ score, and findings were nearly identical. This was not surprising given that a very high correlation was found between PDEQ score and PDI score, $r = .703$, $p < .001$. As with peritraumatic dissociation, a positive, significant relationship was found when PDI score was independently regressed onto IES-R avoidance score, $B = .529$, $p < .001$, DES-R-2 score, $B = .313$, $p < .001$, PTCI score, $B = .524$, $p < .001$, and PTGI score, $B = .207$, $p = .01$. That is, women who reported greater levels of distress during their adolescent sexual assault experiences reported greater posttraumatic levels of avoidance, dissociation, disrupted cognitions, and growth. Means and standard deviations for all peritraumatic measures (assessed at Screening) and posttraumatic measures (assessed at 1-week follow-up) are listed in Table 6.

**Intercorrelations Among Posttraumatic Outcomes**

The proposed model (see Figure 2) projected covariance between posttraumatic avoidance and dissociation and between posttraumatic cognitive discord and lack of growth. To examine the structure of this model, all possible bivariate correlations among these four variables (and peritraumatic measures and revictimization) were

---

1 Linear regression analyses were conducted a second time, controlling for all demographic variables, and statistical patterns were the same.
Table 6

*Means and Standard Deviations for Peritraumatic and Posttraumatic Measures*

<table>
<thead>
<tr>
<th>Measure</th>
<th>M</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peritraumatic Dissociative Experiences Questionnaire</td>
<td>1.93</td>
<td>0.82</td>
</tr>
<tr>
<td>Peritraumatic Distress Inventory</td>
<td>1.88</td>
<td>0.82</td>
</tr>
<tr>
<td>(Avoidance Subscale) Impact of Event Scale-Revised</td>
<td>2.33</td>
<td>0.83</td>
</tr>
<tr>
<td>Dissociative Experiences Scale-Revised-Version 2</td>
<td>2.47</td>
<td>0.71</td>
</tr>
<tr>
<td>Posttraumatic Cognitions Inventory</td>
<td>2.63</td>
<td>0.93</td>
</tr>
<tr>
<td>Posttraumatic Growth Inventory</td>
<td>2.44</td>
<td>1.06</td>
</tr>
</tbody>
</table>
conducted (see Table 7). Partially supporting the structure of the proposed model, posttraumatic avoidance and posttraumatic dissociation were significantly correlated, $r = .343$, $p < .01$. However, the inverse relationship between posttraumatic cognitive discord and posttraumatic growth was not supported ($r = .087$). Instead, this analysis uncovered unpredicted relatedness between posttraumatic cognitive discord and both posttraumatic avoidance, $r = .446$, $p < .01$, and posttraumatic dissociation, $r = .448$, $p < .01$. Also, revictimization was related to cognitive discord, $r = .201$, $p < .05$, but to no other posttraumatic constructs. An additional analysis examining all possible bivariate correlations among the measures, but also controlling for common variance contributed by peritraumatic dissociation, yielded similar intercorrelations.

Table 7

*Bivariate Correlations Among Measures (N = 153)*

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Peritraumatic Dissociation</td>
<td>.703**</td>
<td>.475**</td>
<td>.371**</td>
<td>.386**</td>
<td>.242**</td>
<td>.047</td>
<td></td>
</tr>
<tr>
<td>2. Peritraumatic Distress</td>
<td>.529**</td>
<td>.313**</td>
<td>.524**</td>
<td>.207*</td>
<td>.057</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Posttraumatic Avoidance</td>
<td>.343**</td>
<td>.446**</td>
<td>.348**</td>
<td>.035</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Posttraumatic Dissociation</td>
<td>.448**</td>
<td>.340**</td>
<td>.120</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Posttraumatic Cognitive Discord</td>
<td>.087</td>
<td>.210*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Posttraumatic Growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>-.053</td>
</tr>
<tr>
<td>7. Revictimization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** Correlation is significant at the $p < 0.01$ level (2-tailed)

* Correlation is significant at the $p < 0.05$ level (2-tailed)
Logistic Regression Analysis Examining the Influence of Posttraumatic Sequelae on Sexual Revictimization

Table 8 describes how these cognitive processes – peritraumatic dissociation, posttraumatic avoidance, posttraumatic dissociation, posttraumatic cognitive discord, and lack of posttraumatic growth – were hypothesized, in turn, to be associated with increased vulnerability to revictimization. For this analysis, logistic regression was utilized in accord with the binary response variable, sexual revictimization (see Figure 3). The sexual revictimization criterion was the same as that used to determine victimization for inclusion in the study, that is, revictimization including only SES items that involve sexual intercourse (SES items 6-10; see p. 68).

When all five predictors were entered simultaneously into the regression model, only posttraumatic cognitive discord predicted sexual revictimization, $B = 1.69$, $p < .05$. That is, even in the presence of all other predictors, every 1-point increase on the PTCI scale increased women’s risk of revictimization over the course of a 4.2-month follow-up period by 1.69 times.\(^2\),\(^3\)

\(^2\) The logistic regression analysis was conducted a second time, controlling for all demographic variables, and statistical patterns were the same.

\(^3\) The logistic regression analysis including all predictor variables discussed here in the model accounted for 5.3% of the variance in revictimization, as indicated by the Cox & Snell $R^2$ Square. However, when the same analysis, excluding PTCI, was conducted, the model accounted for only 2.3% of the variance in revictimization. Together, these analyses indicate that cognitive discord alone accounts for approximately 3% of the variance in revictimization.
Table 8

*Logistic Regression Model: Constructs and Measures Utilized*

<table>
<thead>
<tr>
<th>Construct</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Revictimization</strong></td>
<td>Sexual Experiences Survey (Time 2)</td>
</tr>
<tr>
<td><strong>Peritraumatic Dissociation</strong></td>
<td>Peritraumatic Dissociative Experiences Questionnaire (PDEQ)</td>
</tr>
<tr>
<td><strong>Posttraumatic Cognitive Avoidance</strong></td>
<td>Dissociative Experiences Scale Revised – Version 2 (DES–R–2)</td>
</tr>
<tr>
<td></td>
<td>Impact of Event Scale – Revised (IES-R; avoidance subscale)</td>
</tr>
<tr>
<td><strong>Disrupted Posttraumatic Meaning Making</strong></td>
<td>Posttraumatic Cognitions Inventory (PTCI)</td>
</tr>
<tr>
<td>(Lack of) Growth</td>
<td>Posttraumatic Growth Inventory (PTGI)</td>
</tr>
</tbody>
</table>

In addition to testing the primary hypotheses, peritraumatic distress score (PDI; Brunet et al., 2001) was entered into the model in place of PDEQ score, and findings were nearly identical. Specifically, when all five predictors were entered simultaneously into the regression model, only posttraumatic cognitive discord predicted sexual revictimization, \( B = 1.69, p < .05 \). That is, even in the presence of all other predictors, every 1-point increase on the PTCI scale increased women’s risk of revictimization over the course of a 4.2-month follow-up period by 1.77 times.
Figure 3. Logistic Regression Model: Relationship Between Cognitive Variables and Revictimization

Avoidance
Peritraumatic Dissociation (PDEQ)
Avoidance (IES-R)
Dissociation (DES-R-2)

Lack of Resolution
Cognitive Discord (PTCI)
Lack of Positive Growth (PTGI)

Revictimization (Yes or No)
Discussion

Figure 4 depicts a proposed, revised model, supported by the results of the present analyses. This study found that peritraumatic dissociation during the time of adolescent assault involving sexual intercourse independently predicted posttraumatic avoidance, dissociation, cognitive discord, and growth. However, only posttraumatic cognitive discord increased women’s risk of revictimization during a 4.2-month follow-up period. These findings held true when peritraumatic distress score, which was highly correlated with peritraumatic dissociation score, was entered into the model instead of peritraumatic dissociation. In general, this study both confirmed several cornerstones of the sexual victimization literature and shed further light on cognitive processes involved in the posttraumatic symptomatology and revictimization of women who have been the victims of adolescent sexual assault.

Marmar et al. (1997) conceptualized peritraumatic dissociation as a coping mechanism that allows an individual to mentally remove him- or herself from the gravity of trauma in the moment, but, perhaps, at a future cost. Indeed, the findings of multiple studies utilizing various populations, including accident victims, hostages, earthquake survivors, emergency services personnel, and war veterans, have indicated that peritraumatic dissociation may dispose trauma victims to posttraumatic symptoms. Although previous studies with the PDEQ have looked at other female traumatized populations, research is scant that has considered the potential repercussions of real-time dissociation for female victims of sexual assault (but see Griffin et al., 1997). The level of peritraumatic dissociation reported by the sexually victimized sample in the
Figure 4. Revised Model Supported by Linear and Logistic Regression Analyses
present study was consistent with that experienced by the Griffin et al. sample, studied at 2 weeks post-rape. That is, the mean PDEQ score for women in the present study fell in between the high- and low-peritraumatic dissociation cutoff scores established by Griffin et al.

Indeed, the present effort extends the general finding of previous literature – that peritraumatic dissociation predicts degree of posttraumatic stress symptomatology – to a sample of college women who have experienced unwanted sexual intercourse during adolescence. Presently, it was demonstrated that severity of posttraumatic symptoms including avoidance, dissociation, and cognitive discord were significantly predicted by degree of dissociation during the sexual assault in a sample of college women, of whom 47.3% were a year or more post-assault. These findings seem to suggest that the tendency of some women to psychologically dissociate from a sexual trauma as it is occurring does in fact predict an ongoing avoidant strategy. The severity of posttraumatic symptoms experienced by the present sample of women was estimated to hover above a clinical threshold. For example, the sum of scores for only avoidance items on the IES-R for the present sample was just below the high total symptom cutoff level established by Horowitz (1982). Likewise, the mean score for these avoidance items was approximately 1.3 times that obtained for the same items in a study that looked at the most stressful events experienced during the previous 6 months by a non-clinical sample (McDonald, 1997). Also, the mean PTCI score for the present sample was higher than the scores of both the no trauma and trauma with no PTSD groups but lower than the score of the moderate to severe PTSD group in the Foa et al. (1999)
developmental study of the PTCI. In general, women in the present study seemed to be characterized by modestly clinical posttraumatic symptomatology.

Beyond supporting the notion that some victims of sexual assault appear to be predisposed by experiential avoidance during the trauma to a course of avoidant symptomatology, this study found an unexpected relationship between avoidant and dissociative symptoms and cognitive discord. Because of this link, Griffin et al.'s (1997) premonition that a dissociative subtype of persons are characterized by “a failure to process the trauma cognitively” (p. 1081) is somewhat contraindicated by the present findings. Rather, greater endorsement of posttraumatic avoidance and dissociation were significantly related to greater endorsement of disrupted posttraumatic cognitions (albeit discordant cognitions). While future research should more closely examine the nature of the relationship between avoidance and cognition, it is fair to say, based on the present analyses, avoidance fails as an absolute cognitive anesthetic for victims of sexual assault.

The finding that peritraumatic dissociation predicts posttraumatic positive growth was contrary to the expectation that dissociation during the time of the trauma would stunt women’s ability to find positive meaning in their traumatic experiences. However, in interpreting this finding, it is useful to note that the posttraumatic growth measure was positively related both to posttraumatic symptomatology (i.e., IES-R and DES-R-2 scores) and peritraumatic distress. Quite simply, the finding that women who grew more were likely to have experienced greater distress during their assaults and were more symptomatic is counterintuitive but may be explained by the simple notion that women are differentially impacted by their assaults. That is, a woman who is highly
impacted by the distress of her assault may feel as though she has no choice but to grow from a very low place; she may not have begun growing from as high a level as her less-distressed counterpart. Indeed, not only was peritraumatic distress predictive of posttraumatic growth, $r = .207$, $p < .05$, but an additional exploratory analysis revealed that, controlling for peritraumatic distress, peritraumatic dissociation was no longer a predictor of posttraumatic growth. For some women who are the most gravely impacted, growing may be a coping necessity, the only way to push onward. The PTGI scale’s relationship to extraversion and optimism (Tedeschi & Calhoun, 1996) supports this interpretation; traumatic impact and need for growth are likely confounded in considering the relationship between peritraumatic dissociation and self-reported growth.

Despite their relationships among each other, posttraumatic cognitive discord, but neither avoidance nor dissociation, predicted revictimization. That is, although the symptomatic cognitive avoidance born of dissociation during the trauma was linked to posttraumatic cognitive discord, it was the cognitive discord itself (e.g., belief in world dangerousness, self incompetence) that placed women at greater risk. Conceptualized in terms of Horowitz’s cognitive processing theory (1986), disrupted cognitions likely indicate that the working through process has not yet reached completion. The important question raised by the present findings, then, seems to surround why certain women may be stuck in a cycle of cognitive processing that fails to afford them cognitive resolution. Indeed, additional analyses were performed and indicated that the avoidance measure from the IES-R used in this study was significantly, positively related to both reexperiencing items and hyperarousal items on the IES-R, both
correlations at the $p < .001$ level. In a sense, these women seem to be psychologically engaging their traumas as Horowitz’s formula prescribes – fluctuating back and forth between intrusion and avoidance; yet, these same women – either because they are stuck and are unable to achieve cognitive completion or because they simply have not yet achieved it – are at risk for revictimization because of their ongoing cognitive discord.

The question remains, given the failure of the present study to detect any direct connection between avoidance and revictimization, whether avoidance, per se, is harmful to the process of trauma recovery. After all, it is generally recognized in the coping literature that avoidance (i.e., denial) may be beneficial in some circumstances (e.g., Lazarus, 1999). To further investigate this issue, an additional analysis was conducted to determine whether posttraumatic avoidance might place women at particular risk for coerced revictimization (since an avoidant coping strategy may inhibit cognitive resolution concerning decision making in future sexual encounters). Indeed, among women who were revictimized, posttraumatic avoidance independently predicted coerced revictimization, $p = .05$, one-tailed. Although the small sample used in this analysis likely prohibited an affirmative answer to the question of whether women who are revictimized by coercion have been particularly prone toward a risky avoidant course, the relationship between posttraumatic avoidance and future coerced revictimization suggests that further exploration of this possibility is warranted. Moreover, these differential patterns of significant predictors – depending on which assault conditions are considered as the outcome measure – underscore the point that distinct psychological processes may undergird revictimization risk for these two
assault experiences (i.e., rape victimization versus victimization by sexual coercion). Given this, it will be important for future research to begin to isolate disparate sexual victimization and revictimization experiences rather than grouping these qualitatively different experiences as an illusory whole.

Taking a step backward from highly focused analyses at the individual level, the primary findings of this study also emphasize the critical need for future consideration of the ecological issues that likely contribute to the maintenance of posttraumatic symptomatology and, in particular, posttraumatic cognitive discord that has been demonstrated here to place women at higher risk for revictimization (e.g., Grauerholz, 2000). This study, resonating the sentiment of many before it, found that of 167 women who had experienced at least one sexual assault involving vaginal, anal, or oral intercourse since age 14, 162 (97.0%) had been victimized by an acquaintance, merely 14 (8.4%) considered themselves “a victim of an illegal sexual assault or rape,” and only one woman (0.6%) had reported her assault to the police (although she had not pressed charges against the perpetrator). When viewed through a macroscopic lens, avoidance of the trauma of sexual assault is even more palpable. Given the possible link between avoidance and lack of cognitive resolution suggested by the present analyses – a discord that has real implications for increasing risk of revictimization – future research must begin to consider the way that sociocultural avoidance concerning sexual assault infiltrates the minds of individuals. As Grauerholz (2000) points out, “the general lack of social and institutional support for sexual abuse victims represents the social context within which victims…form their identities, self-concepts, and
interactional patterns” (p. 14). Indeed, society necessarily is the envelope within which women must attempt to resolve their ideas and beliefs about victimization.

Future Directions

In addition to reiterating the need to explore the relationships among posttraumatic symptoms such as avoidance, dissociation and cognitive discord for victims of sexual assault, several comments are in order concerning the survey instruments in development or recently published that were used in this study. First, this study supported past findings that obtaining PDEQ score during face-to-face interviews may be an even more sensitive measure of peritraumatic dissociation than the self-report survey version. Indeed, participants’ yes-no responses to the 10 PDEQ items during the interview even more strongly predicted posttraumatic sequelae according to the same trends as the responses obtained during the paper-and-pencil survey. Also, distress experienced during the assault (as measured by the PDI; Brunet et al., 2001) was significantly related to peritraumatic dissociation in sexual assault victims ($r = .703, p < .001$), and, moreover, it predicted posttraumatic symptoms (avoidance $r = .529$, dissociation $r = .313$, cognitive discord $r = .524$; all $ps < .001$) in the same way as peritraumatic dissociation. Further investigation of peritraumatic distress in this population is indicated by these findings.

Despite the convergent validity demonstrated by the significant intercorrelations among the peritraumatic and posttraumatic measures presently utilized (see Table 7), these seemingly impressive relationships simultaneously bring into question the ability of these instruments to adequately discriminate among psychological constructs. For example, this study conceptualized peritraumatic dissociation as an in-the-moment
coping mechanism akin to psychological avoidance that might predict an avoidant, non-engaging future course. However, the high correlation between peritraumatic dissociation and peritraumatic distress seems to indicate that women who dissociate during or just after they are sexually victimized are not doing so to the exclusion of simultaneous emotional engagement with the incident (i.e., distress). Likewise, the highly significant correlations between posttraumatic avoidance and dissociation and posttraumatic cognitive discord suggests that the posttraumatic avoidance and dissociation constructs tapped here were not distinct from cognitive engagement (i.e., disrupted thoughts) regarding the victimization incident. One parsimonious hypothesis concerning the inability of avoidance to predict revictimization in the present study may be that the avoidance construct, as measured by the IES-R, is yet to be purely distilled. While both the peritraumatic and posttraumatic measures used in the present study have clearly demonstrated that they pertain to victims of sexual assault, continued attention to the discriminant validity of these instruments is warranted.

Using the modified SES proved to be important for recruiting women in this study. Koss and Bachar (2001) have pointed out that national research is most often characterized by “dealing with the difficulties of assessing the alcohol and drug rape issue by ignoring these forms of rape completely” (p. 1). For example, while the recent Tjaden and Thoennes (2000) study estimated the prevalence of rape or attempted rape at 17.6%, the present study added an item to the SES not considered in the national survey that proved to be essential in accurately tapping the nature of unwanted sexual experiences that many women endure. Specifically, the question, “have you ever had sexual intercourse (vaginal, anal, or oral) when you didn’t want to because you were
drunk or stoned and were unable to give consent” was endorsed as the highest level of sexual victimization since the age of 14 at screening for 39 of 601 women (or 6.5% of the sample). In fact, the number of women endorsing this item was second only to “have you given in to sexual intercourse (vaginal, anal, or oral) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure” (see Table 2). Supporting the notion that national figures may still underrepresent the incidence of unwanted (and hidden) sexual intercourse, the present study found that 27.8% of women screened endorsed one or more sexual victimization experiences involving vaginal, oral, or anal penetration since the age of 14.

The use of the additional SES item is at once both a strength and a snag for future analyses of the rich data collected here. For example, one weakness of the present study is that, due to financial and logistical limitations, a non-interviewed comparison group could not be included. Given this limitation, although it would be useful to perform a quasi-experimental analysis that considers the effect of the interviews on revictimization rates, other potential comparison studies have failed to tap this non-consenting group of women. Thus, until studies begin to broach the consent issue head on – alcohol or not – women’s experiences will continue to remain uninvestigated and a quasi-experimental comparison will certainly require imprecise methodological extrapolation.

Along similar lines, the present study emphasizes the need for future research to investigate more precisely the many permutations – from lack of consent, to coercion, to forcible rape – of sexual victimization. As the exploratory findings indicate, differential peritraumatic and posttraumatic psychological processes may characterize
these qualitatively distinct experiences, and future investigations should group these
disparate experiences mindfully, and, with purpose (e.g., Testa & Dermen, 1999). The
present study, despite its limitations, contributed to this enterprise by investigating only
women who had been victims of sexual assault involving completed intercourse.
Among these women, those who had experienced a higher degree of dissociation during
their assaults were more likely to later experience greater avoidance, dissociation, and
cognitive discord. Although these posttraumatic symptoms were intercorrelated,
cognitive discord alone placed these women at greater risk of being revictimized within
a period of just over 4 months. These findings emphasize the importance of
interventions that address cognitive discord concerning sexual assault and pave the way
for future research that continues to examine the relationship between avoidance and
cognitive discord and, perhaps, the indirect role of avoidance in sexual revictimization.


*Journal of Traumatic Stress, 5*, 455-475.


APPENDIX A: Informed Consent Forms

Title of Research: Women’s Social Experiences (SCREENING)

Principal Investigators: Audrey Miller, B. A. & Joanna Pashdag, M. A.

Department: Psychology

Federal and university regulations require us to obtain signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study:

This is a screening for a multi-part study. The purpose of the study is to examine the relationship between previous experiences and future life events. The results of this study will aid us in understanding these relationships. If you choose to participate in this screening, you will be asked to fill out questionnaires, some of which will ask for personal and sexual information. Please consider your comfort level with these types of question before agreeing to participate in the screening. This screening involves no physical risks for participants. However, some individuals might experience emotional discomfort. Participation is voluntary, and you may stop responding and withdraw from the screening at any point without penalty. If you have any questions or concerns, the experimenter will be there to assist you. Your total participation today should take less than one hour.

Following this screening session, one of the principal investigators will review your answers to these questionnaires. Depending on your answers to these questionnaires, you may be contacted by telephone or email and asked to participate in the multi-part study, during which you would be asked to fill out additional questionnaires and take part in a short interview. You would receive two additional credits for filling out those questionnaires and one additional credit for the interview. You would also be asked to take part in one additional follow-up session in approximately four months, during which you would fill out additional questionnaires, and for which you would be paid $20.

Today, you will receive an identification number to put on your answer sheet. A master list of names and identification numbers will be kept in a locked file cabinet in a locked office, and will be accessible only by the principal investigators. This identification number will be used on all subsequent questionnaires and the interview. The master list of names will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters is confidential. No individual names will be used in reporting the results of the study.
The principal investigators for this study are Joanna Pashdag (M. A.), Audrey Miller (B. A.), & Christine A. Gidycz (Ph. D.). If you have any questions regarding this survey, please contact any of the following investigators:

Audrey Miller 311-F Porter Hall (594-9151)
Joanna Pashdag 200 Porter Hall (593-1707)
Christine A. Gidycz 231 Porter Hall (593-1092)

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I certify that I am 18 years of age or older. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled.

/s/______________________________          Print __________________
Date_________________________
Informed Consent Form

Title of Research: Women’s Social Experiences (TIME 1)

Principal Investigators: Audrey Miller, B. A. & Joanna Pashdag, M. A.

Department: Psychology

Federal and university regulations require us to obtain signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study:

This is a multi-part study. Its purpose is to examine the relationship between previous experiences and future life events. The results of this study will aid us in understanding these relationships. If you choose to participate, you will be asked to fill out questionnaires and take part in a brief interview. During this study, you will be asked for personal and sexual information. Please consider your comfort level with these types of question before agreeing to participate in the study. This study involves no physical risks for participants. However, some individuals might experience emotional discomfort. Participation is voluntary, and you may stop responding and withdraw from the study at any point without penalty. If you have any questions or concerns, the experimenter will be there to assist you. Your total participation should take approximately two hours (a one-and one-half hour questionnaire session and one 15 to 20 minute interview). You will receive two credits for today’s session and one additional credit for the interview. You will also be asked to take part in one additional follow-up session in approximately four months, during which you will fill out additional questionnaires, and for which you would be paid $20.

You will receive an identification number to put on your answer sheet. A master list of names and identification numbers will be kept in a locked file cabinet in a locked office, and will be accessible only by the principal investigators. This master list of names will be destroyed following the completion of the project (approximately 1 year). Any information you provide to the experimenters is confidential. No individual names will be used in reporting the results of the study.

The principal investigators for this study are Joanna Pashdag (M. A.), Audrey Miller (B. A.), & Christine A. Gidycz (Ph. D.). If you have any questions regarding this survey, please contact any of the following investigators:

Audrey Miller 311-F Porter Hall (594-9151)
Joanna Pashdag 200 Porter Hall (593-1707)
Christine A. Gidycz 231 Porter Hall (593-1092)
If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I certify that I am 18 years of age or older. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled.

/s/ ___________________________          Print ___________________________

Date___________________________
Informed Consent Form

Title of Research: Women’s Social Experiences (INTERVIEW)

Principal Investigators: Audrey Miller, B. A. & Joanna Pashdag, M. A.

Department: Psychology

Federal and university regulations require us to obtain signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

Explanation of Study:

This interview is part of a multi-part study. Its purpose is to examine the relationship between previous experiences and future life events. The results of this study will aid us in understanding these relationships. Today you will be asked to participate in an interview regarding certain sexual experiences. Please consider your comfort level with discussing such experiences before agreeing to participate in the study. This study involves no physical risks for participants. However, some individuals might experience emotional discomfort. Participation is voluntary, and you may stop responding and withdraw from the study at any point without penalty. If you have any questions or concerns, the principal investigator, who is a graduate student in Clinical Psychology, will be present to assist you. Your participation today should take approximately 15 to 20 minutes. You will receive 1 credit for the interview.

Your interview will be recorded on audiotape. Only your identification number will be on the audiotape; your name will not be used. Either the principal investigator or an undergraduate psychology research assistant assigned to this study will transcribe the audiotape. Only your identification number will appear on the transcript. This procedure will assure your anonymity and confidentiality.

The principal investigators for this study are Joanna Pashdag (M. A.), Audrey Miller (B. A.), & Christine A. Gidycz (Ph. D.). If you have any questions regarding this interview, please contact any of the following investigators:

Audrey Miller 311-F Porter Hall (594-9151)
Joanna Pashdag 200 Porter Hall (593-1707)
Christine A. Gidycz 231 Porter Hall (593-1092)

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.
I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I certify that I am 18 years of age or older. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled.

/s/ ____________________________  Print ____________________________

Date ____________________________
Informed Consent Form

Title of Research: Women’s Social Experiences (TIME 2)

Principal Investigators: Audrey Miller, B. A. & Joanna Pashdag, M. A.

Department: Psychology

Federal and university regulations require us to obtain signed consent for participation in research involving human subjects. After reading the statements below, please indicate your consent by signing this form.

**Explanation of Study:**

This is the final part of a multi-part study. Its purpose is to examine the relationship between previous experiences and future life events. The results of this study will aid us in understanding these relationships. Today you will be asked to fill out questionnaires and your participation will take no more than one hour. You will receive twenty dollars at the end of today's session. This study involves no physical risks for participants. However, some individuals might experience emotional discomfort. Participation is voluntary, and you may stop responding at any point and withdraw from the study without penalty. If you have any questions or concerns, the experimenter will be there to assist you.

Your answers will be kept strictly confidential. Remember that your answers are anonymous. Even the experimenters do not know which answers are yours. We are interested in group differences, not individual persons' responses. No individual names will be used in reporting the results of the study.

The principal investigators for this study are Joanna Pashdag (M. A.), Audrey Miller (B. A.), & Christine A. Gidycz (Ph. D.). If you have any questions regarding this survey, please contact any of the following investigators:

Audrey Miller 311-F Porter Hall (594-9151)
Joanna Pashdag 200 Porter Hall (593-1707)
Christine A. Gidycz 231 Porter Hall (593-1092)

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740) 593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I certify that I am 18 years of age or older. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury
resulting from my participation in this research. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled.

/s/___________________________  Print__________________

Date_________________________
APPENDIX B: Background Questions Form

ID________________________   Date_________________________

Name__________________________________________________

Member of sorority:   Yes   No

Home phone number_____________________________________

Best time to call_______________________________________

Do you have any major medical problems?   Yes   No

Do you exercise?   Yes   No

How often do you exercise?________________________________

Do you smoke?   Yes   No

How much do you smoke?_________________________________

Do you take a daily vitamin?   Yes   No

Have you ever had an extended hospital stay?   Yes   No

If so, for what reason?_________________________________

Are you currently receiving treatment for psychological or emotional reasons?

Yes   No

If so, what for?________________________________________

Are you taking any medications for psychological or emotional reasons?

Yes   No

Medication name and dosage________________________________
Have you ever thought about hurting yourself?  Yes  No

If yes, have you ever tried to hurt yourself?  Yes  No

If yes, how?__________________________________________

When was the last time you thought about hurting yourself?

_____________________________________________________

Did you seek help when you felt this way before (e.g., call a friend or family member, call hotline, etc.)?  Yes  No

Are you currently thinking about hurting yourself?  Yes  No

If yes, describe the nature of your thoughts. ____________________________

________________________________________________________

Have you thought about what you might do?  Yes  No

Do you intend to do this?  Yes  No

Do you think you will?  Yes  No
APPENDIX C: Contact Form

Because this is a multi-part study, depending on your answers to the questionnaires, you may be called back to participate in subsequent parts of the study – including another questionnaire session, a short interview, and another brief questionnaire session in four months – for which you will earn an additional three points and $20. Because students sometimes move or change their phone numbers, we would like a way to reach you if your number changes. If we cannot reach you by phone, we will first attempt to reach you by email. The phone number of a parent or relative who is sure to know your new number would be helpful as well. If we were to call, we would simply say that we are calling from O. U. about an experiment that you participated in. We would not give any specifics about the study. However, if you are uncomfortable with our using either your email address or a contact phone number, please leave it off.

Your Name__________________________________________
Your current phone___________________________________
Your current email____________________________________
Your home address___________________________________
___________________________________________________
___________________________________________________

Contact Name_______________________________________
Contact Phone_______________________________________

Contact Name_______________________________________
Contact Phone_______________________________________
APPENDIX D: Demographics Questionnaire

Please use the green answer sheet – do not write on this paper. We would like to start by asking you some general information first. Please fill in the appropriate letter on the green answer sheet.

1. What is your age?
   A. 18    C. 20    E. 22
   B. 19    D. 21    F. Over age 22

2. What is your current year in school?
   A. Freshman    C. Junior    E. Graduate
   B. Sophomore    D. Senior    F. Other

3. What is your ethnicity?
   A. Caucasian, Non-Hispanic    D. Hispanic
   B. African American    E. American Indian or Alaska Native
   C. Asian or Pacific Islander    F. Other

4. What is your religion?
   A. Catholic    C. Jewish    E. None
   B. Protestant    D. Nondenominational    F. Other

5. What is your sexual orientation?
   A. Heterosexual    B. Homosexual    C. Bisexual

6. What is your current marital status?
   A. Never married    C. Married    E. Divorced
   B. Co-habitating    D. Separated    F. Widowed

7. What is your current dating status?
   A. I do not date.    D. I am engaged
   B. I date casually.    E. I am married.
   C. I am involved in a long-term monogamous relationship (duration of 6 months or longer).

8. Have you ever willingly had sexual intercourse?
   A. Yes    B. No
9. How old were you when you first willingly had sexual intercourse?
   A. Does not apply - I have never willingly had sexual intercourse.
   B. 13 years old or younger
   C. 14
   D. 15
   E. 16
   F. 17
   G. 18
   H. 19 years old or older

10. How many consensual (not forced) sexual partners have you had?
    A. 0
    B. 1
    C. 2
    D. 3
    E. 4
    F. 5
    G. 6
    H. 7 or more

11. How often do you drink alcohol?
    A. I never drink or have not drunk in the past year.
    B. I drink less than once a month, but at least once in the past year.
    C. I drink one to three times a month.
    D. I drink one to two times a week.
    E. I drink more than twice a week.

12. On a typical drinking occasion, how much do you usually drink? (Choose one)
    A. None
    B. Usually no more than 3 cans of beer (or 2 glasses of wine or 2 drinks of distilled spirits)
    C. Usually no more than 4 cans of beer (or 3 glasses of wine or 3 drinks of distilled spirits)
    D. Usually no more than 5 or 6 cans of beer (or 4 glasses of wine or 4 drinks of distilled spirits)
    E. Usually more than 6 cans of beer (or 5 or more glasses of wine or distilled spirits)

13. In the last two months, how often did you drink to the point of intoxication or drunkenness (that is, feeling dizzy, feeling ill, passing out, or feeling out of control? (Estimate if you are unsure. Choose one.)
    A. I have never drank to the point of being drunk.
    B. I got drunk 1-3 times in the past two months.
    C. I got drunk 4-5 times in the past two months.
    D. I got drunk 6-10 times in the past two months.
    E. I got drunk 11-15 times in the past two months.
    F. I got drunk 16-20 times in the past two months.
    G. I got drunk 21-25 times in the past two months.
    H. I got drunk more than 25 times in the past two months.
APPENDIX E: Sexual Experiences Surveys

i. Adolescent Victimization

**Please answer the following questions about your sexual experiences from age 14 on.**

**Have you had any of these experiences from the age of 14 on?**

1. Have you ever given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

About how many times since age 14 years?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

2. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man used his authority (boss, teacher, camp counselor, supervisor) to make you?

About how many times since age 14 years?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

3. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.)?

About how many times since age 14 years?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

4. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did not occur?

About how many times since age 14 years?

A. 0  D. 3
B. 1  E. 4 or more
C. 2
5. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by giving you alcohol or drugs, to prevent you from resisting, but intercourse did not occur?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

6. Have you ever had sexual intercourse (vaginal, anal, or oral) when you didn’t want to because you were drunk or stoned and were unable to give consent?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

7. Have you given in to sexual intercourse (vaginal, anal, or oral) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

8. Have you had sexual intercourse (vaginal, anal, or oral) when you didn't want to because a man used his position of authority (boss, teacher, counselor, supervisor)?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

9. Have you had sexual intercourse (vaginal, anal, or oral) when you didn't want to because a man gave you alcohol or drugs to prevent you from resisting?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2
10. Have you had sexual intercourse (vaginal, anal, or oral) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?

About how many times since age 14 years?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

11. Look back at questions 1-10. What is the highest question number to which you answered "yes"?

a. 1  f. 6  
b. 2  g. 7  
c. 3  h. 8  
d. 4  i. 9  
e. 5  j. 10

***For the following questions, refer to the highest question number to which you answered "yes". If you have had this experience with more than one person on different occasions, refer to the most significant time this occurred.

12. How many men did this experience involve?
   a. One man (1)  
   b. Two men (2)  
   c. Three or more men (3+)

13. What was your relationship to the man/men at the time? (If more than one man was involved, what was your relationship to the most significant one?)
   a. Stranger  
   b. Non-romantic acquaintance (friend, neighbor, ex-husband, etc.)  
   c. Casual or first date  
   d. Romantic acquaintance (steady date, boyfriend, lover)  
   e. Husband  
   f. Father  
   g. Step-father  
   h. Uncle  
   i. Brother
14. How well did you know him/them?
   a. Didn't know at all  d. Very well acquainted
   b. Slightly acquainted e. Extremely well acquainted
   c. Moderately acquainted

15. How many times has he/they done this to you?
   a. 1 d. 4
   b. 2 e. 5 or more
   c. 3

16. How long ago did it happen?
   a. Less than 3 months  d. 1-2 years
   b. 3-6 months e. 3-5 years
   c. 6 months to a year f. Over 5 years

17. Looking back on the experience, how would you describe the situation? (Please choose only one.)
   a. I don’t feel I was victimized
   b. I believe I was a victim of serious miscommunication
   c. I believe I was a victim of sexual coercion
   d. I believe I was a victim of an illegal sexual assault or rape

18. Did you report this incident to anyone? (Please choose the highest level to which you have reported the incident. For example, if you reported the incident to both a mental health worker and law enforcement, choose D and not C).
   a. I have not told anyone
   b. I have only told a close friend or family member
   c. I have informed a school, medical, or mental health worker but have not informed the police
   d. I have informed the police of the incident
   e. I have informed the police of the incident and have pressed charges
ii. Adult victimization

Please answer the following questions about your experiences since you last filled out this survey approximately four months ago.

Have you had any of these experiences since you last filled out this survey approximately four months ago?

1. Have you given in to sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

   About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
   A. 0  D. 3
   B. 1  E. 4 or more
   C. 2

2. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man used his authority (boss, teacher, camp counselor, supervisor) to make you?

   About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
   A. 0  D. 3
   B. 1  E. 4 or more
   C. 2

3. Have you had sex play (fondling, kissing, or petting, but not intercourse) when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.)?

   About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
   A. 0  D. 3
   B. 1  E. 4 or more
   C. 2
4. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by threatening or using some degree of force (twisting your arm, holding you down, etc.) but intercourse did not occur?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

5. Have you had a man attempt sexual intercourse (get on top of you, attempt to insert his penis) when you didn't want to by giving you alcohol or drugs, to prevent you from resisting, but intercourse did not occur?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

6. Have you had sexual intercourse (vaginal, anal, or oral) when you didn’t want to because you were drunk or stoned and were unable to give consent?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
A. 0  D. 3
B. 1  E. 4 or more
C. 2

7. Have you given in to sexual intercourse (vaginal, anal, or oral) when you didn't want to because you were overwhelmed by a man's continual arguments and pressure?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?
A. 0  D. 3
B. 1  E. 4 or more
C. 2
8. Have you had sexual intercourse (vaginal, anal, or oral) when you didn't want to because a man used his position of authority (boss, teacher, counselor, supervisor)?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

9. Have you had sexual intercourse when you didn't want to because a man gave you alcohol or drugs to prevent you from resisting?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

10. Have you had sexual intercourse when you didn't want to because a man threatened or used some degree of physical force (twisting your arm, holding you down, etc.) to make you?

About how many times has it happened (since the last time you filled out this survey approximately 4 months ago)?

A. 0  D. 3
B. 1  E. 4 or more
C. 2

11. Look back at questions 1-10. What is the highest question number to which you answered "yes"? (If you answered zero to every one of these questions, that is, you have not had any of these experiences in the last 4 months, please answer the following questions in terms of the incident that you discussed during your interview for this study.)

A. 1  F. 6
B. 2  G. 7
C. 3  H. 8
D. 4  I. 9
E. 5  J. 10
***Considering the highest question number to which you answered "yes" on questions 1-10, please answer the following questions referring to the most significant time this occurred.

12. How many men did this experience involve?
   A. One man (1)
   B. Two men (2)
   C. Three or more men (3+)

13. What was your relationship to the man/men at the time? (If more than one man was involved, what was your relationship to the most significant one?)
   A. Stranger
   B. Non-romantic acquaintance (friend, neighbor, ex-husband, etc.)
   C. Casual or first date
   D. Romantic acquaintance (steady date, boyfriend, lover)
   E. Husband
   F. Father
   G. Step-father
   H. Uncle
   I. Brother

14. How well did you know him/them?
   A. Didn't know at all          D. Very well acquainted
   B. Slightly acquainted        E. Extremely well acquainted
   C. Moderately acquainted

15. How many times has he/they done this to you?
   A. 1 D. 4
   B. 2 E. 5 or more
   C. 3

16. How long ago did it happen?
   A. Less than 3 months   D. 1-2 years
   B. 3-6 months          E. 3-5 years
   C. 6 months to a year  F. Over 5 years

17. Looking back on the experience, how would you describe the situation? (Please choose only one).
   A. I don't feel I was victimized
   B. I believe I was a victim of serious miscommunication
   C. I believe I was a victim of sexual coercion
   D. I believe I was a victim of an illegal sexual assault or rape
18. Did you report this incident to anyone? (Please choose the highest level to which you have reported the incident. For example, if you reported the incident to both a mental health worker and law enforcement, choose D and not C).
   A. I have not told anyone
   B. I have only told a close friend or family member
   C. I have informed a school, medical, or mental health worker but have not informed the police
   D. I have informed the police of the incident
   E. I have informed the police of the incident and have pressed charges
Appendix F: Peritraumatic Dissociative Experiences Questionnaire

If you reported any incidents in the previous questionnaire (the SES), please read the following statements and mark the choice that best describes your experiences and reactions during and immediately after the most significant incident that you reported.

Please use the following scale:

A. Not at all true
B. Slightly true
C. Somewhat true
D. Very true
E. Extremely true

1. I had moments of losing track of what was going on – I "blanked out" or "spaced out" or in some way felt that I was not part of what was going on.

2. I found that I was on "automatic pilot" – I ended up doing things that I later realized I hadn't actively decided to do.

3. My sense of time changed – things seemed to be happening in slow motion.

4. What was happening seemed unreal to me, like I was in a dream or watching a movie or play.

5. I felt as though I were a spectator watching what was happening to me, as if I were floating above the scene or observing it as a spectator.

6. There were moments when my sense of my own body seemed distorted or changed. I felt disconnected from my own body, or that it was unusually large or small.

7. I felt as though things that were actually happening to others were happening to me – like I was being trapped when I really wasn't.

8. I was surprised to find out afterward that a lot of things had happened at the time that I was not aware of, especially things I ordinarily would have noticed.

9. I felt confused; that is, there were moments when I had difficulty making sense of what was happening.

10. I felt disoriented; that is, there were moments when I felt uncertain about where I was or what time it was.
Appendix G: Peritraumatic Distress Inventory (PDI)

If you reported any incidents in the first questionnaire (SES), please read the following statements and mark the choice that best describes your experiences and reactions during and immediately after the most significant incident that you reported.

Please use the following scale:

A. Not at all true
B. Slightly true
C. Somewhat true
D. Very true
E. Extremely true

1. I felt helpless to do more.

2. I felt sadness and grief.

3. I felt frustrated or angry I could not do more.

4. I felt afraid for my safety.

5. I felt guilty that more was not done.

6. I felt ashamed of my emotional reactions.

7. I felt worried about the safety of others.

8. I had the feeling I was about to lose control of my emotions.

9. I had difficulty controlling my bowel and bladder.

10. I was horrified by what happened.

11. I had physical reactions like sweating, shaking, and my heart pounding.

12. I felt I might pass out.

13. I thought I might die.
Appendix H: Impact of Event Scale - Revised (IES-R)

The following is a list of difficulties people sometimes have after stressful life events. During the screening session for this study, you indicated that you had experienced unwanted sexual activity between the age of 14 and the time of the screening session. Please answer the following questions in regard to that incident. Please read the following statements and indicate how distressing each difficulty has been for you during the past 7 days with respect to the most significant incident that you reported during the screening session. Use the following scale:

A. Not at all
B. A little bit
C. Moderately
D. Quite a bit
E. Extremely

1. Any reminder brought back feelings about it.
2. I had trouble staying asleep.
3. Other things kept making me think about it.
4. I felt irritable and angry.
5. I avoided letting myself get upset when I thought about it or was reminded of it.
6. I thought about it when I didn't mean to.
7. I felt as if it hadn't happened or wasn't real.
8. I stayed away from reminders about it.
9. Pictures about it jumped into my mind.
10. I was jumpy and easily startled.
11. I tried not to think about it.
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.
13. My feelings about it were kind of numb.
14. I found myself acting or feeling like I was back at that time.
15. I had trouble falling asleep.
16. I had waves of strong feelings about it.
17. I tried to remove it from my memory.
18. I had trouble concentrating.
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.
20. I had dreams about it.
21. I felt watchful and on guard.
22. I tried not to talk about it.
Appendix I: Dissociative Experiences Survey Revised – Version 2

Mark the answer that shows how much this happens to you. Use the following scale:

This happens to me:

A. Never
B. It has happened once or twice.
C. No more than once a year.
D. Once every few months.
E. At least once a month.
F. At least once a week.

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip.

2. Some people find sometimes that they are listening to someone talk and they suddenly realize that they did not hear all or part of what has just been said.

3. Some people have the experience of finding themselves in a place and they have no idea how they got there.

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on.

5. Some people have the experience of finding new things among their belongings that they do not remember buying.

6. Some people sometimes find that they are approached by people that they do not know who call them by name or insist that they have met before.

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.

8. Some people are told that they do not recognize friends or family members.

9. Some people find that they have no memory for some important events in their lives, for example a wedding or graduation.

10. Some people have the experience of being accused of lying when they do not think that they have lied.
11. Some people have the experience of looking in a mirror and not recognizing themselves.

12. Some people sometimes have the experience of feeling that other people, objects, and the world around them are not real.

13. Some people sometimes have the experience of feeling that their body does not seem to belong to them.

14. Some people have the experience of sometimes remembering a past event so vividly that they feel as if they were reliving that event.

15. Some people have the experience of not being sure if things that they remember happening really did happen or whether they just dreamed them.

16. Some people have the experience of being in a familiar place and finding it strange and unfamiliar.

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.

18. Some people find that they become so involved in fantasy or a daydream that it feels as though it were really happening to them.

19. Some people find that they are sometimes able to ignore pain.

20. Some people find that they sometimes sit staring off into space thinking of another event and are not aware of the passage of time.

21. Some people sometimes find that when they are alone they sometimes talk out loud to themselves.

22. Some people find that in one situation they may act so differently compared to another situation that they feel almost as if they were two different people.

23. Some people sometimes feel that in some situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them, for example, sports or social situations, etc.

24. Some people sometimes find that they cannot remember whether they have done something or have just thought about doing that thing, for example, whether they have just mailed a letter or just thought about mailing it.

25. Some people sometimes find evidence that they have done things that they do not remember doing.
26. Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing.

27. Some people sometimes find that they hear voices in their head that tell them to do things or comment on what they are doing.

28. Some people sometimes feel as if they are looking at the world through a fog so that people or objects appear far away or unclear.

29. Some people find that when they are reading a book, they sometimes lose track of what happens around them for a period of time.

30. Some people have had the experience of being in a situation that would usually make them very emotional, but feel no emotion at all (although they are very aware of what is happening around them).

31. Some people have had the experience of smelling an odor or hearing a sound and then briefly "spacing out" or becoming lost in a memory or thought.

32. Some people find themselves singing the words to a song they know, but do not remember when they started singing it or how it came into their minds.

33. Some people find themselves driving someplace automatically that they go to frequently, such as their office, workplace, or school, when they meant to take a different road or route to someplace else.

34. Some people are able to self-hypnotize or meditate and become unaware of their surroundings very easily.

35. Some people bite their fingernails and don't realize they are doing it.

36. Some people find that when others tell them a story of anger or pain, they "catch" the feeling and find it difficult not to become angry, sad, or anxious themselves.

37. Some people find that they become so absorbed in sad movies that they cry.

38. Some people find that when they see a frightening movie, they continue to be frightened after the movie ends and they are out of the theater.

39. Some people find that when they are telling an emotional story, they get so caught up in the emotion that they lose their place and can't remember what they have said and/or what point they are making.
40. Some people find that when they are part of an emotional crowd experience, like a ball game or a music performance, they become caught up in the crowd's behavior and do or say things that are different than the way they would normally behave.

41. Some people find that an event on the news captures their attention so vividly that they cannot stop watching it or thinking about it.
Appendix J: Posttraumatic Cognitions Inventory (PTCI)

During the screening session for this study, you indicated that you had experienced unwanted sexual activity between the age of 14 and the time of the screening session. Please answer the following questions in regard to that incident. Please read the following statements and indicate how much you AGREE or DISAGREE with each statement. Answer with respect to the most significant incident that you reported during the screening session.

People react to events in many different ways. There are no right or wrong answers to these statements. Please use the following scale:
A. Totally disagree
B. Disagree very much
C. Disagree slightly
D. Neutral
E. Agree slightly
F. Agree very much
G. Totally agree

1. The event happened because of the way I acted.
2. I can't trust that I will do the right thing.
3. I am a weak person.
4. I will not be able to control my anger and will do something terrible.
5. I can't deal with even the slightest upset.
6. I used to be a happy person but now I am always miserable.
7. People can't be trusted.
8. I have to be on guard all the time.
9. I feel dead inside.
10. You can never know who will harm you.
11. I have to be especially careful because you never know what can happen next.
12. I am inadequate.
13. I will not be able to control my emotions, and something terrible will happen.
14. If I think about the event, I will not be able to handle it.
15. The event happened to me because of the sort of person I am.
16. My reactions since the event mean that I am going crazy.
17. I will never be able to feel normal emotions again.
18. The world is a dangerous place.
19. Somebody else would have stopped the event from happening.
20. I have permanently changed for the worse.
21. I feel like an object, not a person.
22. Somebody else would not have gotten into this situation.
23. I can't rely on other people.
24. I feel isolated and set apart from others.
25. I have no future.
26. I can't stop bad things from happening to me.
27. People are not what they seem.
28. My life has been destroyed by the event.
29. There is something wrong with me as a person.
30. My reactions since the event show that I am a lousy coper.
31. There is something about me that made the event happen.
32. I will not be able to tolerate my thoughts about the event, and I will fall apart.
33. I feel like I don't know myself anymore.
34. You never know when something terrible will happen.
35. I can't rely on myself.
36. Nothing good can happen to me anymore.
Appendix K: Posttraumatic Growth Inventory (PTGI)

During the screening session for this study, you indicated that you had experienced unwanted sexual activity between the age of 14 and the time of the screening session. Please answer the following questions in regard to that incident. Answer with respect to the most significant incident that you reported during the screening session.

Indicate for each of the statements below the degree to which this change occurred in your life as a result of the incident to which you answered “yes,” using the following scale:

A. I did not experience this change as a result of the incident.
B. I experienced this change to a very small degree as a result of the incident.
C. I experienced this change to a small degree as a result of the incident.
D. I experienced this change to a moderate degree as a result of the incident.
E. I experienced this change to a great degree as a result of the incident.
F. I experienced this change to a very great degree as a result of the incident.

1. I changed my priorities about what is important in life.
2. I developed an appreciation for the value of my own life.
3. I developed new interests.
4. I developed a feeling of self-reliance.
5. I developed a better understanding of spiritual matters.
6. I know that I can count on people in times of trouble.
7. I established a new path for my life.
8. I developed a sense of closeness with others.
9. I developed a willingness to express my emotions.
10. I know that I can handle difficulties.
11. I’m able to do better things with my life.
12. I’m able to accept the way things work out.
13. I appreciate every day.
14. New opportunities are available which wouldn’t have been available otherwise.

15. I have compassion for others.

16. I put effort into my relationships.

17. I’m more likely to try to change things that need changing.

18. I have a stronger religious faith.

19. I discovered that I’m stronger than I thought I was.

20. I learned a great deal about how wonderful people are.

21. I accept needing others.
APPENDIX L: Interview Format

1. As you know, we have asked you to take part in this study because you indicated that sometime between the age of 14 and the start of this quarter, you had an unwanted sexual experience. Please tell me about that experience, from its start to its finish, in your own words. If it happened more than once, please talk about the incident that bothers or bothered you the most. If you become uncomfortable while talking about it, please say so. Remember, you are free to stop at any time.

2. How has this incident you have described impacted your life?

3. I will now ask you to consider your experiences and reactions during and immediately after this incident. Please answer yes or no to the following questions.

   (Close-ended PDEQ questions asked here; see Appendix F).

4. In terms of labels that society uses to describe incidents like this, what do you call what happened to you, and why?

5. Did you report the incident to law enforcement – why or why not?

6. This is a difficult subject for many women to talk about. On a scale of 1 to 10, with 1 being "very comfortable" and 10 being "very upset," how would you rate your level of comfort or distress at this moment?

7. Briefly, why did you agreed to participate in this study and interview?
DEBRIEFING INFORMATION (Screening)

Thank you for your participation in this screening for a multi-part study. The study's objective is to examine the relationship between previous experiences and future life events. To accomplish this goal, you were asked questions about personal life events, including psychological, physical, and sexual experiences. The responses to these questions will be compared with other students who have differing life events.

Your participation will help us understand how previous experiences are related to later life experiences. As a reminder, your answers will be kept strictly confidential.

Depending on your answers to these questionnaires, you may be contacted by telephone and asked to participate in the remaining parts of the study. If you have any questions, please feel free to ask the survey administrator. If you would like further information, here are some suggested places to contact:

1) Hudson Health Counseling Center (CPS): Phone: 593-1616
   Campus agency that can give further assistance or information.

2) Tri-County Community Mental Health Center: Phone: 592-3091
   Community agency that can provide assistance or information

3) Project Supervisor: Christine A. Gidycz 231 Porter Hall (593-1092)

4) Principal Investigators: Audrey Miller 311-F Porter Hall (594-9151)
   Joanna Pashdag 200 Porter Hall (593-1707)
DEBRIEFING INFORMATION (Time 1)

Thank you for your participation in this study. The study's objective is to examine the relationship between previous experiences and future life events. To accomplish this goal, you were asked questions about personal life events, including psychological, physical, and sexual experiences. The responses to these questions will be compared with other students who have differing life events.

Your participation will help us understand how previous experiences are related to later life experiences. As a reminder, your answers will be kept strictly confidential.

A researcher will call you to arrange and/or confirm a day and time for the interview portion of this study. If you have any questions, please feel free to ask the survey administrator. If you would like further information, here are some suggested places to contact:

1) Hudson Health Counseling Center (CPS): Phone: 593-1616
   Campus agency that can give further assistance or information.

2) Tri-County Community Mental Health Center: Phone: 592-3091
   Community agency that can provide assistance or information

3) Project Supervisor: Christine A. Gidycz 231 Porter Hall (593-1092)

4) Principal Investigators: Audrey Miller 311-F Porter Hall (594-9151)
   Joanna Pasdag 200 Porter Hall (593-1707)
DEBRIEFING INFORMATION (Interview)

Thank you for your participation in this study. The study's objective is to examine the relationship between previous experiences and future life events. To accomplish this goal, you were asked questions about personal life events, including psychological and sexual experiences. Your responses to these questions will be compared with other students' responses to help us understand these relationships.

As a reminder, your answers will be kept strictly confidential.

A researcher will give you a reminder call one week before your sign-up date for part 2 of this study, in approximately four months. If you have any questions, please feel free to ask the interviewer, who will remain available for approximately 15 minutes following the conclusion of this interview. If you would like further information, here are some suggested places to contact:

1) Hudson Health Counseling Center (CPS): Phone: 593-1616
   Campus agency that can give further assistance or information.

2) Tri-County Community Mental Health Center: Phone: 592-3091
   Community agency that can provide assistance or information

3) Project Supervisor: Christine A. Gidycz 231 Porter Hall (593-1092)

4) Principal Investigator: Audrey Miller 311-F Porter Hall (594-9151)
   Joanna Pashdag 200 Porter Hall (593-1707)
DEBRIEFING INFORMATION (Time 2)

Thank you for your participation in this study. The study's objective is to examine the relationship between previous experiences and future life events. To accomplish this goal, you were asked questions about personal life events, including psychological, physical, and sexual experiences. The responses to these questions will be compared with other students who have differing life events.

Your participation will help us understand how previous experiences are related to later life experiences. As a reminder, your answers will be kept strictly confidential.

If you have any questions, please feel free to ask the survey administrator. If you would like further information, here are some suggested places to contact:

1) Hudson Health Counseling Center (CPS): Phone: 593-1616
   Campus agency that can give further assistance or information.

2) Tri-County Community Mental Health Center: Phone: 592-3091
   Community agency that can provide assistance or information

3) Project Supervisor: Christine A. Gidycz 231 Porter Hall (593-1092)

4) Principal Investigators: Audrey Miller 311-F Porter Hall (594-9151)
   Joanna Pashdag 200 Porter Hall (593-1707)