PTSD AND ASSOCIATED FEATURES AS PREDICTORS OF
REVICTIMIZATION AND PERPETRATION WITH SAMPLES OF
ADULTS ABUSED DURING CHILDHOOD

by

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Abstract

Two-hundred and twenty-four participants who reported a history of child abuse trauma were recruited from the internet, clinical (community outpatient) and prison settings and completed a battery of assessment measures, including Briere's Child Maltreatment Interview Schedule (CMIS) (slightly modified), Detailed Assessment of Traumatic Stress (DAPS), Cognitive Distortion Scale (CDS), and Inventory of Altered Self Capacities (IASC); van der Kolk's Self Inventory of Disorders of Extreme Stress (SIDES-SR); Nijenhuis's Somatoform Dissociation Questionnaire (SDQ-20); and a modification of the CMIS to assess for adult victimization experiences (Adult Victimization Survey or AVS; Dietrich, unpublished instrument). It was hypothesized that Posttraumatic Stress Disorder (PTSD), Affect Dysregulation, and Problems with Interpersonal Relatedness would be associated with later revictimization experiences during adulthood with this sample, and that disturbances in ability to regulate self capacities and other complex posttraumatic sequelae would be associated with perpetration of physical or sexual violence during adulthood. Data were analyzed for 207 individuals who reported childhood maltreatment per the CMIS. Results provide partial support for the hypotheses. Women were significantly more likely to report revictimization, and male inmates were significantly more likely to perpetrate against others. Whereas PTSD and Somatoform Dissociation are the strongest dynamic predictors of any sexual or physical revictimization, Impaired Self Capacities are more often associated with revictimization by intimate partners in particular. Trauma-specific dissociation was associated with a
decreased risk of revictimization, whereas peritraumatic and trait dissociation did not enter predictive models. Posttraumatic sequelae were not associated with increased risk of physical perpetration with these samples; however, IASC scores were associated with an increased risk of sexual perpetration and victim-based cognitive distortions were associated with decreased odds of sexual violence. These findings provide partial support for the Complex PTSD (Herman, 1992a) construct. Results are discussed in terms of implications for treatment, further study, and classification. Limitations are noted.
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Dedication

This work is dedicated to trauma survivors and their families. At the time these data were being collected, the New York City Trade Center and the United States Pentagon were bombed by terrorist attacks. Thousands of individuals lost their lives. This work is also dedicated to the victims and families of civilian and military casualties from the “War on Iraq,” which occurred at the time these data were being analyzed. The effects of trauma are felt worldwide, and although trauma clearly can and does beget trauma, the capacity of individuals who have been traumatized to give to others was exemplified by several participants in this study. These individuals donated their research honoraria, which was pooled and sent to The United Way International specifically for families of the terrorist attacks. Finally, this work is dedicated to those individuals who continue to suffer the adverse effects of traumatic childhoods, and to those children who are today being traumatized. Hopefully research and advocacy on trauma prevention and intervention will one day decrease the rates of traumatization and suffering in society.
Chapter 1. Introduction

When I was in my mid forties, a 65-year old priest propositioned me sexually...I found myself reacting strangely - I felt helpless and "dirty" and had trouble thinking clearly or articulating why I didn't want to do this. He kissed me on the mouth and started to fondle my breast and I felt sort of "paralyzed" in resisting. But I was able to leave...This episode led to a three-day period of dual consciousness (that of normal adult self watching in the background, and that of myself as a small child in the forefront) in which I recalled important details of my sexual abuse by a minister at age 5. The child consciousness was sort of an extended flashback complete with visuals and body sensations...

-- 53 year-old study participant

I went to his office, and he invited me to sit down for a "chat." After a few minutes, he began commenting on my physical appearance, with specific reference to my sexual anatomy. (I fell into a state of stunned disbelief. The words were the same words my uncle used when he sexually abused me as a kid). He walked over to me and began to fondle my breasts. I couldn't move. Some time later -- I'm not sure how much time had passed -- he told me I had better go. I spent the next several days in a state of pain and confusion - it was happening again. I felt the same as I had with my uncle -- all the conflicting, confusing feelings came back, but I felt I was able to cope with them better now. It was as though I was a kid and an adult at the same time. I kept asking myself over and over -- "Why didn't I stop him?" I had felt powerless to resist, as though I somehow "knew" that resisting or fighting wouldn't help, that it was easier to just surrender and get it over with.

--25 year-old study participant

An extensive body of empirical literature has documented myriad longterm negative effects of chronic childhood maltreatment, including (but not limited to) Posttraumatic Stress Disorder (PTSD) and Associated Features to PTSD (American Psychiatric Association, 2000). One of the most robust findings is that women who have experienced childhood sexual abuse are at high risk of sexual revictimization (Arata, 2000; Arata & Lindman, 2002; Becker-Lausen, Sanders & Chinsky, 1995; Cloitre, 1998; Collins, 1998; Fergusson, Horwood & Lynskey, 1997; Gidycz, Coble, Latham & Layman, 1993; Gidycz, Hanson, & Layman, 1995; Kellogg & Hoffman, 1997; Kessler & Bieschke, 1999; Koverola, Proulx, Battle & Hanna, 1996; Krahe, Scheinberger-Olwig, Waizienhofer, & Kolpin, 1999; Proulx, Koverola, Fedorowicz, & Kral, 1995; Sanders & Moore, 1999; Stermac, Reist,
Addison, & Millar, 2002; West, Williams, & Siegel, 2000; cf. Mandoki & Burkhart, 1989; Mayall & Gold, 1995), with reported sexual revictimization rates ranging from 6% to 68.8%.

Adults with childhood maltreatment histories are also at increased risk of physical and/or psychological abuse during adulthood (Messman-Moore & Long, 2000; Nishith, Mechanic, & Resick, 2000; Noll, Horowitz, Bonanno, Trickett, & Putnam, in press; Schaaf & McCanne, 1998), with reported physical victimization rates of adults with childhood abuse histories ranging from 24.2% to 51.4%, and reported rates of psychological victimization from 62% to 70.8%. This variation in rates appears to be based in methodological variations, including definitions of abuse, age cutoffs that are used when assessing for revictimization, and variations in samples.

Revictimization

Empirical studies have explored the role of PTSD and other difficulties associated with childhood maltreatment as predictors of revictimization. Although PTSD and many associated features of childhood maltreatment are correlated with revictimization, the predictive status of many of these variables remains equivocal. Variations in findings may be based, in part, in variations in the methodologies used in the studies, including variations in the populations that have been sampled, in how various researchers define childhood abuse and revictimization, and in terms of measurement issues (such as choice of instrument).
The importance of empirical identification of risk factors for subsequent revictimization cannot be understated. Repeated traumatization tends to result in more severe psychological impairments (e.g., Breslau, Chilcoat, Kessler, & Davis, 1999; Follette, Polusny, Bechtle, & Naugle, 1996; van der Kolk, 1996), and appears to increase risk of physical health impairments as well (De Bellis & Putnam, 1994; De Bellis, Burke, Trickett, & Putnam, 1993; Felitti et al., 1998; Heim et al., 2000; Wilson, van der Kolk, Burbridge, Fisler & Kradin, 1999).

The identification of risk factors for revictimization can assist in prevention of revictimization of individuals with known histories of childhood maltreatment and can provide foci for intervention with adults who are experiencing revictimization (e.g., domestic violence) or have been revictimized. Actuarial instruments to assess for risk of revictimization can be developed and studied empirically, for eventual use in clinical practice. Compassionate understanding of factors that place individuals at increased risk can assist with decreasing “victim blame,” particularly within the legal system.

Research shows that women and children who have experienced sexual assault/abuse frequently blame themselves for the assault, even when there is clear evidence to the contrary (Briere, 2000; van der Kolk, Waisaeth, & McFarlane, 1996). Moreover, perpetrators routinely project blame and responsibility onto their victims (e.g., see Dutton, 1998). When individuals who have been abused become involved with the legal system, they may be perceived by police officers, lawyers, and judges as being at least partly responsible for the abuse they have experienced. For example, one high profile
case several years ago in British Columbia received extensive media coverage after a judge ruled that a 3-year old girl was "sexually aggressive," thereby reducing the responsibility of the adult perpetrator who had sexually abused her. This bias is also found in larger societal contexts, where victims are viewed as somehow provoking the abuse. A more recent example occurred in the United States where a young teenage girl was abducted from her home by a man and his wife. This young girl had been abused and manipulated such that she did not try to flee or draw attention to herself as a victim, even when in the safety of the police. As noted by psychologist Marylene Cloitre on the television documentary "American Justice," if this young girl had been found murdered, the focus and outrage would be on the perpetrator(s). However, all attention focused on the young girl and the fact that she did not try to flee, even when opportunities to flee were available. There appears to be an obvious connection between such victim behavior and the "inescapable shock" phenomenon observed in animal studies, where animals that are subjected to uncontrollable shock (trauma) and are prevented escape later fail to take appropriate action (flee), even when opportunities to do so are obvious and available (Overmier & Seligman, 1967; Rosellini & Seligman, 1976; Seligman & Maier, 1967).

Abuse-related cognitive distortions may be labeled as "delusional" (implying personal deficiency or impaired reality-testing) and abuse-related coping strategies may be incorrectly perceived as implying victim complicity, rather than as being adaptations to the experience of terrifying, uncontrollable situations. It is suggested that when professionals and lay persons adopt such
judgments of victims, there are deficiencies in the understanding of the dynamics of abuse and assault. Research that draws attention to the peritraumatic or posttraumatic psychological sequelae that increase the individual’s vulnerability to continued or subsequent victimization may assist in decreasing such judgments and reduce victim blame (e.g., see Dutton & Painter, 1989).

In this study, my primary aim is to expand on the research to date that has examined risk factors for revictimization (sexual and physical) of adults with various forms of childhood maltreatment histories. A second aim, discussed in a subsequent section, is to identify risk factors for perpetration by adults with childhood maltreatment histories. Cloitre (1998) examined the revictimization literature and arranged the empirical correlates of revictimization into three main categories of risk factors: Affect Dysregulation, Problems with Interpersonal Relatedness, and Posttraumatic Stress Disorder. These postulated risk factors show clear conceptual similarities to the construct of Complex Posttraumatic Stress Disorder (C-PTSD) (Herman, 1992a). Specifically, my goal is to examine risk factors involving affect dysregulation, interpersonal relatedness problems, and PTSD as predictors of sexual revictimization, physical revictimization, and revictimization by intimate partners. The predictors used in this study were selected based on findings from the empirical literature to date, and were specifically chosen due to their relationship to childhood maltreatment.

**Overview of Complex PTSD**

Complex PTSD (C-PTSD) was a focus of the DSM-IV field trial on PTSD. Researchers for the DSM-IV field trial on PTSD examined the literature on
childhood abuse, and compiled a list of 54 different problems that had been studied in various research projects. These 54 problems were arranged into seven clusters: Affect Dysregulation, Amnesia and Dissociation, Altered Self-perceptions, Altered Relationships with Others, Altered Perceptions of the Perpetrator, Somatization, and Altered Systems of Meaning. This constellation of symptom clusters was referred to as "Complex PTSD" by Herman (1992a, b) and as "Disorders of Extreme Stress, Not Otherwise Specified" (DESNOS) by van der Kolk and colleagues (1996). Although the construct was considered for inclusion as a distinct category in the DSM nomenclature, at the end of deliberations the symptom clusters were included in the DSM-IV as "Associated Features" to PTSD (with the exception of "altered perceptions of the perpetrator," which was dropped due to low reliabilities in the field trial). According to the American Psychiatric Association (1994, p. 425),

"The following associated constellation of symptoms may occur and are more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture): impaired affect modulation; self-destructive and impulsive behavior; dissociative symptoms; somatic complaints; feelings of ineffectiveness, shame, despair, or hopelessness; feeling permanently damaged; a loss of previously sustained beliefs; hostility; social withdrawal; feeling constantly threatened; impaired relationships with
others; or a change from the individual's previous personality characteristics."

As noted, this set of features is consistent with several of the risk factors for revictimization and as will be seen, for some postulated risk factors for perpetration as well. Thus, there are conceptual similarities between C-PTSD and the risk factors for revictimization as identified by Cloitre (1998). My primary research question for this study is “Do posttraumatic sequelae of affective dysregulation, altered relationships, and PTSD increase the risk of revictimization of adults with childhood maltreatment histories?”

**Contributions to the Current Literature on Revictimization**

In addition to utilizing the risk factors identified by Cloitre (1998) as a conceptual framework in the study of predictors of revictimization, this study adds to the current literature by sampling from populations (e.g., correctional facilities) that have not heretofore been examined in relation to risk factors for revictimization. Moreover, the current study adds to the literature by examining different forms of childhood maltreatment per Briere’s (1992a) Child Maltreatment Interview Schedule (CMIS) and includes various forms of revictimization per a modified CMIS that assesses for victimization during adulthood. That is, in addition to assessing for childhood maltreatment with the CMIS, I modified the original CMIS and reworded the items such that they assess for victimization (sexual, physical, psychological) during adulthood, and for perpetration during adulthood. Finally, the current study adds to the literature in that several of the measures that are used to examine the role of various
posttraumatic predictors are normed, standardized measures (with the exception of the SIDES-SR) that are specifically developed to assess for posttraumatic and complex posttraumatic sequelae rather than general psychological impairment. Although most studies that have examined risk factors for revictimization have included at least some trauma-specific measures, many have utilized general symptom measures.

With regard to how my study contributes to clarification in regard to methodological problems in previous research, as noted, the current design includes trauma-specific measures as potential predictors of revictimization, rather than generic measures, which should assist in clarification of the postulated trauma-specific sequelae as risk factors for revictimization. In addition, I am using an upper cutoff age of 17 in defining childhood, in comparison to many studies who have utilized age 14 as the upper cutoff. The Child Maltreatment Interview Schedule that is used in this study inquires into exact ages at which various forms of maltreatment occurs, and thus analyses can be conducted with the upper age cutoff specified anywhere up to age 17. This increase in breadth of definition of childhood abuse will help solve the potential problem of low base rates, which would reduce predictive power. The definitions of various forms of childhood abuse that I use in this study are fully explicated in the Method chapter. Moreover, many studies have included adolescent abuse experiences as constituting revictimization following childhood abuse rather than categorizing this as child abuse. Since adolescence is a specific developmental stage when identity is being formed, abusive experiences at this time would likely
impact subsequent symptomatology in different ways than would revictimization that occurs during adulthood, and may also impact normative developmental processes. As such, revictimization was not held to occur in this study until the individual was at least age 18. Thus, traumatic victimization experiences during formative developmental periods are distinguished from revictimization experiences during adulthood. A further way in which this study differs from many other revictimization studies is that I sample from older populations. The average age of the women in studies of revictimization with student samples is around 20 years. Older samples would have more time in which to be potentially revictimized, thus increasing base rates of revictimization and enhancing predictive power. Finally, demographic variables (race, sex, age) are entered as covariates in analyses in order to statistically control for potential differences between groups.

One might wonder at this point what the logic is behind looking at victims and perpetrators simultaneously in the development of models of revictimization. Basically, perpetrator status and victim status are not necessarily mutually exclusive. Individuals who have childhood maltreatment histories are at increased risk of victimization experiences during adulthood, whether or not they also perpetrate violence. In order to control for any potential differences in terms of predictors of revictimization of those who are known to perpetrate and do not perpetrate violence, indicator variables were used in regression analysis. That is, group status (correctional facility, non correctional facility) and other demographic variables were dummy coded and were entered into the predictive
The reasoning behind this is that any differences between perpetrators and non-perpetrators in terms of predictors of revictimization would show up in the model as a predictor (the predictor would be “group status”). If there are no differences between groups, group status would not conceivably enter the model as a predictor of revictimization.

Perpetration

The second aim of this study is to identify risk factors that predict perpetration of violence against others by those who were maltreated during childhood. Although it would appear that the majority of individuals with child maltreatment histories do not commit serious offenses against others (e.g., see Gilgun, Klein & Pranis, 2000; Hamilton, Falshaw, & Browne, 2002; Widom, 1989), childhood maltreatment has been shown to be a common feature of the histories of incarcerated juvenile and adult offenders, with some reported rates as high as 93% (e.g., see Erwin, Newman, McMackin, Morrissey, & Kaloupek, 2000; Macri, 1999; Spitzer et al., 2001; Veneziano, Veneziano, & LeGrand, 2000; Vilsker, 1999; Weeks & Widom, 1998).

Childhood maltreatment has been conceptualized as a static risk factor for later violent perpetration (e.g., see Webster, Eaves, Douglas & Wintrup [Dietrich], 1996) and sexual perpetration (e.g., see Boer, Hart, Kropp, & Webster, 1997); however, there are reasonable grounds to consider childhood maltreatment sequelae as dynamic risk factors for later violent and/or sexual recidivism. Static risk factors are those that are fixed and not changeable, whereas dynamic risk factors are those that are amenable to intervention, and
thus can serve to decrease or increase a given individual's risk of offense. Post-childhood maltreatment sequelae may function to increase a given individual's risk of offending against others. Empirical studies have documented positive correlations between being a violent or sexually violent offender and affect dysregulation, interpersonal relatedness problems, and altered self perceptions (e.g., see Dutton, 1998). However, to my knowledge, few studies have examined these factors as predictors of interpersonal violence. My secondary research question for this study is "Do dynamic, posttraumatic sequelae (affective dysregulation, altered relationships, and PTSD) increase the risk of perpetration of physical or sexual violence by adults with childhood maltreatment histories?"

Contributions to the Current Literature on Perpetration

The identification of factors that increase risk of perpetration is important because knowledge of these factors can assist social service personnel in the identification of children and adolescents who are at increased risk of perpetration and provision of psychological intervention to prevent later violent or sexual acting out. In addition, identification of factors that are empirically related to both childhood maltreatment and subsequent offending could provide foci for intervention with known offenders, to assist them in decreasing their risk of violent or sexual acting out. The findings may be useful for informing current treatment programs within correctional facilities. For example, integrating treatment of posttraumatic sequelae with treatment models may improve treatment effectiveness and reduce recidivism rates.
The Current Study

Measures

The measures chosen for this study include the Self Inventory for Disorders of Extreme Stress (SIDES-SR), the Detailed Assessment of Posttraumatic Stress (DAPS), the Multiscale Dissociation Inventory (MDI), the Cognitive Distortion Scales (CDS), the Inventory of Altered Self Capacities (IASC), the Somatoform Dissociation Questionnaire (SDQ-20), the Child Maltreatment Interview Schedule (CMIS), and a modified CMIS to measure victimization and perpetration during adulthood (Adult Victimization Survey or AVS). Each of these measures was specifically developed to measure symptoms that are empirically related to childhood maltreatment.

The SIDES-SR (van der Kolk, unpublished) is a modification of the original Structured Interview for Disorders of Extreme Stress (SIDES) that was used in the field trial on PTSD. The original SIDES interview has established reliability and validity (Newman, Riggs, & Roth, 1997; Pelcovitz et al., 1997; Roth, Newman, Pelcovitz, van der Kolk, & Mandel, 1997; van der Kolk et al., 1996; Zlotnick & Pearlstein, 1997). The original interview was re-worded into self-report format, and one of the original SIDES scales (altered perceptions of the perpetrator) was dropped due to low reliabilities in the field trial. The SIDES-SR, which is used for this study, assesses affect dysregulation, dissociation, alterations in self perceptions, alterations in relationships with others, somatization, and altered systems of meaning. The content of the SIDES-SR, when used in conjunction with measures of PTSD, parallels the C-PTSD criteria.
The SIDES-SR has good reported internal consistency (Luxenberg, Spinazzola, & van der Kolk, 2001). The Disorders of Extreme Stress Not Otherwise Specified (DESNOS) construct upon which the SIDES-SR is based (DESNOS with PTSD and C-PTSD are the same construct) has established validity (see Luxenberg et al., 2001 for a summary).

The remaining symptom measures used in this study (the Detailed Assessment of Posttraumatic Stress, the Multiscale Dissociation Inventory, the Cognitive Distortions Scales, and the Somatoform Dissociation Questionnaire) correspond to the risk factors that were identified by Cloitre (1998), and tap into constructs that are theoretically related to C-PTSD. The DAPS is a normed, standardized instrument that assesses for the full DSM-IV-TR criteria for Acute Stress Disorder (ASD), PTSD, peritraumatic dissociation, trauma-specific dissociation, suicidality, and substance abuse. This instrument relates to the C-PTSD criteria (per the SIDES-SR) in that PTSD, suicidality, and dissociation are all components of C-PTSD. The MDI assesses for DSM-IV-TR criteria for the Dissociative disorders, and assesses for state/trait dissociation, whereas the CDS assesses for cognitive distortions that survivors of childhood maltreatment frequently evidence, including negative perceptions about self and safety (which are also criteria for C-PTSD). The IASC assesses for features that are frequently observed with those who have experienced chronic or severe childhood maltreatment, and includes affect regulation problems, interpersonal relatedness problems, and identity impairments. The items of the IASC reflect symptoms and behaviors that are traditionally associated with Borderline Personality Disorder.
(and which are incorporated into the criteria set for C-PTSD). Finally, the SDQ-20 assesses for a particular form of dissociation, referred to as Somatoform Dissociation. Somatoform dissociation is frequently observed with those who have been sexually abused and who suffer from symptoms of both DSM-IV-TR dissociative disorders and somatization disorders (Nijenhuis, 1999). The SDQ-20 items would correspond to several of the symptoms from the SIDES-SR Somatization scale. The theoretical relationships between Cloitre’s risk factors, the SIDES-SR and the various measures are depicted in Table 1. Cloitre’s risk factors are depicted in the left-hand column; Complex PTSD criteria (PTSD plus Disorders of Extreme Stress) are depicted in the middle column; the theoretically-related measures used in this study are shown in the right-hand column.
Table 1

Theoretical Convergence between Cloitre’s Risk Factors, the Self-Inventory for Disorders of Extreme Stress (SIDES-SR), the Detailed Assessment of Posttraumatic Stress (DAPS), the Multiscale Dissociation Inventory (MDI), the Cognitive Distortions Scales (CDS), and the Somatoform Dissociation Questionnaire (SDQ-20)

<table>
<thead>
<tr>
<th>Cloitre’s Risk Factors*</th>
<th>Complex PTSD (PTSD and Disorders of Extreme Stress, or SIDES-SR Criteria)</th>
<th>Other Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>PTSD</td>
<td>PTSD</td>
<td>DAPS PTSD scale</td>
</tr>
<tr>
<td>Affect Dysregulation</td>
<td>SIDES-SR Scale I - Affect Dysregulation</td>
<td>IASC Affect Dysregulation Scales</td>
</tr>
<tr>
<td>(emotional flooding and numbing)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affect Dysregulation</td>
<td>SIDES-SR Scale II - Alterations in Attention and Consciousness (Dissociation)</td>
<td>DAPS Trauma-specific Dissociation</td>
</tr>
<tr>
<td>(dissociation)</td>
<td></td>
<td>MDI Dissociation Scales</td>
</tr>
<tr>
<td>Affect Dysregulation</td>
<td>SIDES-SR Scale V - Somatization</td>
<td>SDQ-20 (Somatoform Dissociation)</td>
</tr>
<tr>
<td>(somatization)</td>
<td></td>
<td>Somatoform Dissociation Questionnaire</td>
</tr>
<tr>
<td>Altered Relationships</td>
<td>SIDES-SR Scale III - Altered Self Perceptions</td>
<td>IASC Identity Impairment Scales</td>
</tr>
<tr>
<td>(based in altered sense of self)</td>
<td></td>
<td>Cognitive Distortions Scales</td>
</tr>
<tr>
<td>Altered Relationships</td>
<td>SIDES-SR Scale IV - Altered Relationships with Others</td>
<td>IASC Altered Relationships Scales</td>
</tr>
<tr>
<td>(based in interpersonal behaviors)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note. I sub-divided Cloitre’s Affect Dysregulation Factors to clarify the conceptual similarity between her risk factors and the Complex PTSD criteria. In addition, I subdivided her risk factor category of Interpersonal Relatedness in terms of interpersonal behaviors and included interpersonal relatedness based in altered views of self.
Analyses

Internal consistency coefficients were calculated to assess reliability of the trauma-specific measures with the current samples. In addition, zero-order correlations were conducted to determine the degree to which these various trauma-based measures evidence convergent validity with the SIDES-SR, and factor analysis of the SIDES-SR and the other measures was conducted as a further test of the validity of the SIDES-SR and other measures used in this study.

To examine the potential role of the postulated risk factors in revictimization, hierarchical logistic regression analyses (controlling for demographic variables) were conducted to identify risk factors for sexual, physical, and intimate partner violence during adulthood. Since family environment variables during childhood have been shown to impact victimization during adulthood, hierarchical regression was used to assess the relative contributions of these variables in revictimization, and any effects were partialled (along with effects of demographic variables) in order to determine the effects of posttraumatic risk factors over and above the effects of demographics and childhood adversity. Empirical findings show that those who are victimized during adulthood report more separation from mother during childhood (Mandoki & Burkhart, 1989); childhood neglect (Noll et al., in press; Sanders & Moore, 1999; Stermac et al., 2002; however, see Arata & Lindman, 2002 for discrepant findings); less feelings of closeness to mother during childhood (Stermac et al., 2002); less feelings of closeness to father during childhood and adolescence...
(Stermac et al., 2002); incest (Kessler & Bieschke, 1999); family of origin problems (Draucker, 1997; Kellogg & Hoffman, 1997; Koverola et al., 1996; Krahe et al., 1999; Stermac et al., 2002; however, see also Banyard, Arnold & Smith, 2000; Gidycz et al., 1995 for discrepant findings); and parental antisocial behavior and maternal drug abuse (Maker, Kemmelmeier, & Peterson, 2001).

The effects of complex posttraumatic sequelae per the SIDES-SR, DAPS, MDI, CDS, IASC, and SDQ-20 were thus assessed over and above the effects of demographics and family and childhood maltreatment factors.

To examine the potential role of the postulated risk factors in perpetration, hierarchical logistic regression analyses (controlling for demographic variables) were also conducted to identify risk factors for sexual and physical perpetration against others during adulthood. Family environment variables during childhood may also impact perpetration during adulthood, and hierarchical regression was used to assess the relative contributions of these variables in perpetration. The effects of complex posttraumatic sequelae per the SIDES-SR, DAPS, MDI, CDS, IASC, and SDQ-20 on perpetration were assessed over and above the effects of demographics and family and childhood maltreatment factors.
Chapter Two: Empirical Data on Revictimization and Perpetration

In this section, I include studies published in the past 15 years and identified through the American Psychological Association’s PsychInfo database and the National Center for PTSD (PILOTS) database using various search terms, including “childhood abuse and revictimization”, “revictimization,” “childhood abuse and perpetration,” and “perpetration.”

Several empirical studies have focused on various sequelae of childhood maltreatment as possible predictors of revictimization (see Table 2 for a summary). Cloitre (1998) has arranged these sequelae into three main classes of risk factors, including affect regulation problems, problems with interpersonal relatedness based in earlier abuse, and Posttraumatic Stress Disorder (PTSD). Cloitre’s arrangement will constitute the organizing structure used for the current study (note that the correspondence between the results in Table 2 and Cloitre’s categorization scheme is not explicitly indicated in Table 2, but is implicit within the “key results” column).

Affect dysregulation, problems with interpersonal relatedness, and PTSD are frequently observed in offender populations as well (e.g., see Barnard, Hankins, & Robbins, 1992; Brinded, Simpson, Laidlaw, Fairley, & Malcolm, 2001; Brooke, Taylor, Gunn, & Maden, 1996; Burton, Foy, Bwanausi, Johnson, & Moore, 1994; Cauffman, Feldman, Waterman, & Steiner, 1998; Friedrich et al., 2001; Giannuli, 2001; Haapasalo & Pokela, 1999; Jordan, Schlenger, Caddell, & Fairbank, 1997; Macri, 1999; McElroy, Soutullo, Taylor, Nelson, Beckman, Brusman, Ombaba, Strakowski, & Keck, 1999; Raymond, Coleman, Ohlerking,
Christenson, & Miner, 1999; Spitzer et al., 2001; Teplin, Abram, & McClelland, 1996; Vilsker, 1999; Zlotnick, 1997).
cope more than control group. Repeated measures group
CSA and repeated measures groups used escapism to
cope more than control group. Repeated measures group
reported more severe CSA than
Control group:

CSA severity were not significant discriminators.

repeated measures, Coping style, attributions, especially
between those who were and were not
professional the only variable that discriminated
sexual activity. Treatment by mental health
lack of material support predicted consensual

Sexual violence (27% of variance)

and adult victimization (27% of variance)

Victimization: CSA predicted # partners, which predicted adult

Victimization: Personality variables did not predict adult

<table>
<thead>
<tr>
<th>Study</th>
<th>N</th>
<th>Race</th>
<th>Mean</th>
<th>Gender</th>
<th>Age</th>
<th>Age of other</th>
<th>Abuse</th>
<th>Other</th>
<th>Victim</th>
<th>Design</th>
<th>%</th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>
Depression.

Groups did not differ on somatization, anxiety, or depression. Controls reported more family conflict and less cohesion than other groups, but no longer significant when controlling for characteristics of the group. Controls reported higher levels of posttraumatic stress and CSA than non-revictimized groups. Revictimized CSA more frequent CA and more severe during revictimization group reported higher levels of revictimized group.

More defensive avoidance than control: sexual concern than control. Group CSA had sexual behaviors, impaired self-esteem, and psychological symptoms of depression, posttraumatic stress disorder, and anxiety. CA and CSA had more anger and anxiety. CSA differed on all TSL scales except anxiety. Controls: controlling for adult victimization, the control and no differences between CA and CSA, with no differences between CA and CSA and CSA more likely to meet PTSD criteria.

The revictimized group:

Except for predicted greater SC-R symptoms with
self-blame than control group; used more negotiation, instrumental action, and
selecting the self was not related to
reported were not related to victimization; however, physical and emotional
CA and CSA were correlated with sexual
predicted victimization, according to the
self-blame, IES, and higher consensual, sex, which
Evidence suggests severity of CSA predicted
blame for CSA and higher IES intrusion and
revealed that more self
revealed that more consensual sex partners than non
revealed that more severe CSA and
controlling for marital status, age, income and
control group
controlling for psychological maltreatment as adults than the
CSA group reported more sexual victimization,
CSA group reported more likely to be victimized than
CSA group reported more likely to be victimized than
CSA group more likely to be victimized than
sexual trauma did not
trauma predicted PTE but whereas non
revised criteria for lifetime PTSD whereas non
revealed group was more likely than other
higher T1 elevations than controls.
Depression and anxiety at baseline, the greater
to revictimization, the higher severity of
Adol's 24 depression and anxiety directly related
Revictimization;
report revictimization, CSA predicted Adol's 24 and
Those with sexual abuse history were more likely to
treported revictimization, CSA, predicted Adol's 24 and
Those with sexual abuse history were more likely to
reported revictimization, CSA predicted Adol's 24 and
Those with sexual abuse history did not report
Significant
between CSA and anxiety, was no longer
Revictimization; CSA with depression, and
sexual-assault, the
controlling for adult sexual assault, the
severity of CSA did not improve the model;
years older did not predict revictimization.
Revictimization; CSA with someone less than 5
CSA with someone 5+ years older predicted
sexual
24.7%
physical and psychological dating aggression.
controlling for FES conflict, CSA predicted
FES conflict, expressive or conflict;
violence, no group differences on self-hating
physical dating violence and psychological dating
Those with CSA were more likely to report
Revictimization.
those with single incident sexual assault; PTSD and dissociation symptoms than incidence of the IPV was less severe, perceived women who were involved in social and control group. Those of the victims who had those with single-incident sexual assaults (longer duration) more risk sexual assault, longer to recognize a PTSD-R scores

higher likelihood of re-victimization with higher moderate, such a history of Sx and leads to dissociation, did not moderate; Posttraumatic Sx to predict re-victimization, and thus do not moderate;
dissociation and posttraumatic stress did not dissociation, and to posttraumatic stress; Previous severe abuse related to re-victimization, to predict re-victimization.

were depression and anxiety at T3, which were significant in the only mediating variable that were significant, and alcohol use did not predict re-victimization.

Sex partners at baseline, but # of sex partners & problems with trust and assertiveness, and # of alcohol victims at baseline; alcohol victims at baseline; # problem CAs, but it did predict depression and predict CSA. Family dysfunction did not predict CAs, but it did predict depression and re-victimization; Severity of re-victimization predicted severity of previous sexual victimization predicted re-victimization in each follow-up time period.

The severity of re-victimization in the following:

<table>
<thead>
<tr>
<th>Patient</th>
<th>Mental</th>
<th>W %</th>
<th>&gt;14</th>
<th>9.48</th>
<th>130</th>
<th>1999</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exp.</td>
<td>18</td>
<td>6</td>
<td>&gt;14</td>
<td>5%</td>
<td>1.27</td>
<td></td>
</tr>
</tbody>
</table>

Model = 65% VAC
to engage in risky health behaviors. Those who experienced one incident of childhood abuse tended to have more symptoms and were more likely to have been treated in a hospital. Those who experienced two or more incidents of childhood abuse tended to have more symptoms and were more likely to have been treated in a hospital. Those who experienced three or more incidents of childhood abuse tended to have more symptoms and were more likely to have been treated in a hospital. Those who experienced four or more incidents of childhood abuse tended to have more symptoms and were more likely to have been treated in a hospital. Those who experienced five or more incidents of childhood abuse tended to have more symptoms and were more likely to have been treated in a hospital.
nullified (than non-revictimized).

predict current PTSD). Neither CSA nor CPA predicted current PTSD. Neither CSA nor CPA predicted sexual assault or physical victimization during adulthood, other than recent rape.

CSA predicted sexual or physical victimization.
for childhood neglect (p = 0.07) and sexual
physical victimization/intimate violence/abuse
sexual assault (p = 0.07). Association predicted
Trend for emotional abuse to predict rape or
problems. More likely to report various gynecological
positive attitudes toward sexually
odds of recidivism (sexual or physical) were 4.3 to 1
substance abuse, lower self-esteem, less
sexually abused women, before CSAs involved force. Those who
more problems with emotional abuse and more problems with
physical abuse in adult relationships, and were
CSA's severity of CSA and intimate partner violence
predicated recidivism in the subsequent year.
CPSA, severity of CSA, attempted rape, and rape.
victimization is a significant predictor of later
severity remained significant predictor of later
et al. 1997
Ferguson 520 18
> 16.4
P < 0.05
CSA: 62%
Neg: 36.32
al. 2002
Steiman et al. 277
52% 36.59 34.76 Retino
History of maternal neglect and CSA increased
decreased odds of sexual assault after age 13.
father and closest to father at age 14 and up
odds of sexual assault after age 13. Increased by
> 14
50 = 12.9
CSA:
2000
West et al. 113
25.3% 84%
> 18
100%
F (50 = 3.2) B
30%
Pros.
Collins 315 17.64
71% 40%
Prospective

F
5.30 = 0.01
18.81 94%
> 14
50 = 15.59
60%
Pros.
No et al. 140
18.81 94%
> 14
50 = 15.59
60%
Pros.

Includes non-contact CSA

F (22-72) W 65% 38.4% 31% Experiment. All had PTSD. Reestablished reported more victimization/domestic violence. 

0.05 (p < 0.01) to predict physical violence.
Perhaps paramount to this investigation, childhood maltreatment/neglect and posttraumatic sequelae have been recognized by experts from both the trauma and forensic fields as potential risk factors for later offending behavior (Briggs & Hawkins, 1996; Carrion & Steiner, 2000; Cima, Merckelbach, Klein, Shellbach-Matties, & Kremer, 2001; Cloitre, Tardiff, Marzuk, Leon, & Portera, 2001; Collins, & Bailey, 1990; Crimmins, Cleary, Brownstein, Spunt, & Warley, 2000; Dutton, 1998, 1999; Dutton & Hart, 1992a, 1992b; Friedrich et al, 2001; Giannuli, 2001; Haapasalo & Kankkonen, 1997; Haywood, Kravitz, Wasyliw, Goldberg, & Cavanaugh, 1996; McElroy et al., 1999; Miccio-Fonseca, 2000; Rivera & Widom, 1990; Romano & DeLuca, 1997; Ward, 1995; Worling, 1995); however, few peer-reviewed, published studies have empirically examined these sequelae in predictive models of violence. What follows is a summary of the empirical literature on revictimization and on perpetration in relation to affect regulation problems, interpersonal relatedness problems, and PTSD.

Problems with Affect Regulation

Affect dysregulation is defined as “alternating experiences of emotional flooding and numbing” (Cloitre, 1998, p. 280). As noted by Cloitre, abuse can directly contribute to affect regulation problems because it promotes chronic arousal (which may interfere with the ability to consistently modulate affect), and it may contribute indirectly in that the learning of effective affect regulation skills would likely be impeded in abusive families (e.g., through poor modeling). Cloitre subsumes the following empirically studied symptoms and behaviors under affect dysregulation: Dissociation; Emotional Flooding and Numbing; Alexithymia; and
Substance Abuse. Affect dysregulation is believed to increase risk of revictimization insofar as it interferes with the individual’s ability to appraise or cope with dangerous situations, thereby impeding appropriate fight or flight responses when at imminent risk of victimization.

Ward, Hudson and Keenan (1998) propose that affect regulation is a major factor in sexual offending, wherein offenders may perpetrate because they are (1) under-regulating affect states, such that negative emotions lead to behavioral disinhibition or disruption, where the individual loses control over his/her behavior, thoughts or emotions in response to negative events or states; or (2) are mis-regulating affect states, such that the individual tries to reach goals with ineffective strategies, such as using alcohol or sexual fantasy to modulate negative affect, or using thought suppression to avoid negative thoughts, which increases risk of perpetration. Ward et al. also postulate that sex offenders may perpetrate in order to attain or maintain positive affect. Affect regulation problems are also correlated with intimate partner violence (Dutton, 1998, 1999).

Dissociation

Dissociation is a multi-faceted construct that has several different meanings. Generally speaking, it refers to the lack of connection between cognition, emotion, perceptions, sensation, behavior, and/or memories. Dissociation has been conceptualized as a normative response to stressful events (Vermetten, Bremner, & Spiegel, 1998), as a normative response during traumatic events (i.e., peritraumatic dissociation) (Marmar, 1997), as a
posttraumatic coping mechanism (Briere, 2001), and as a clinical phenomenon
that is thought to have its basis in extreme trauma (e.g., American Psychiatric
Association, 2000).

Peritraumatic dissociation refers to acute dissociative symptoms that occur
during the traumatic event. They can be conceptualized as a protective
mechanism, which appears to be based in innate survival mechanisms (e.g., see
Levine, 1997). In this sense of the term, *peritraumatic dissociation* functions as a
last resort that increases chances of survival when opportunities to fight or flee
are impossible. Several studies have found that peritraumatic dissociation is a
risk factor for PTSD (e.g., see Yehuda, 1999).

Dissociative experiences may persist after the event is over, in what Briere
(2001) has referred to as “trauma-specific dissociation.” This refers to symptoms
of derealization, depersonalization, and detachment that closely follow and are
specifically related to the index traumatic event, and correspond to Associated

Trauma-specific dissociation is distinguished from trait or state dissociation.
When dissociative symptoms are pervasive and longstanding, they are viewed as
pathological states/traits (American Psychiatric Association, 2000; Briere, 2002a).
These dissociative phenomena may involve disturbances in consciousness,
memory, emotion, perception, identity, and behavior (Briere, 2000) as well as
movement and sensation (Nijenhuis, 1999). Clinicians and researchers have
theorized that dissociation is a key factor in revictimization (e.g., Chu, 1992).
Dissociation and Revictimization. Although dissociation is correlated with sexual revictimization (Cloitre, Scarvalone, & Difede, 1997; Field et al., 2001), its predictive validity has been inconsistent. Becker-Lauser et al. (1995) found that dissociation mediated childhood maltreatment and negative life outcomes during adulthood (including revictimization) with students, and Noll et al. (in press) found that dissociation predicted physical victimization with their community/clinical sample. Two other studies using student samples did not support dissociation as a mediator of childhood abuse and sexual revictimization (Kessler & Bieschke, 1999; Sandberg, Matorin, & Lynn, 1999). Revictimized female students were slower than non-revictimized female students in identifying a high risk audiotaped date-rape scenario as high risk in an experimental study. Dissociation as measured by the DES did not predict latency even though those who waited longer had lower trauma-related arousal (Wilson, Calhoun & Bernat, 1999). Retrospective ratings of peri-traumatic dissociation failed to predict violent victimization (a composite of sexual and/or physical victimization) during adulthood with an Australian convenience sample (Irwin, 1999).

Thus, although dissociation was correlated with sexual revictimization in two studies, it failed to predict sexual revictimization in two others. The role of dissociation as a predictor of sexual revictimization is equivocal. Possible reasons for the discrepant findings include methodological variations between the studies, which will be discussed later in this chapter. Dissociation was found to predict physical victimization of individuals with childhood abuse histories, and mediated
childhood maltreatment and general negative life outcomes, which was a composite dependent variable that included revictimization experiences.

Different measures were used to assess dissociation in the above studies. Several studies used the Dissociative Experiences Scale, which includes items that are considered to be "normal dissociation" and items that constitute a "pathological dissociation taxon" (Waller & Ross, 1997). Two studies used measures that assess for trauma-specific dissociation, and one assessed for peritraumatic dissociation.

Dissociation and Perpetration. Empirical evidence documents child abuse histories and dissociative coping mechanisms among spousal assaulters. Simoneti, Scott, and Murphy (2000) found that one third of their sample of 47 male spousal assaulters reported experiencing dissociation during intimate partner violence, with males who witnessed parental violence during childhood having the highest dissociation scores, relative to those with childhood sexual or physical abuse histories. The frequency of physical aggression was significantly correlated with dissociative symptoms for the full sample. Similarly, Dutton (1995) found that dissociation was significantly related to physical and verbal abuse of spouses, and appeared to have its origins in childhood maltreatment.

Higher rates of childhood trauma, anger-rage, and more post-traumatic stress disorder (PTSD), dissociative, and CNS symptomatology were found with a sample of incarcerated adult male sex offenders as compared to a group of employed adult males (Hulnick, 1997); however, the role of dissociation as a predictor was not examined. Similarly, Graham (1993) found higher Dissociative
Experiences Scale (DES) scores were reported by a sample of sex offenders than by non-sex offenders and community controls.

In a later study, Graham (1996) found that male sex offenders who were physically abused by both parents reported higher levels of dissociation than those who were not, and Ward (1995) found significant correlations between dissociation as per the Dissociative Experiences Scale (DES) and age at onset of sexual abuse and number of sexual abuse incidents with a sample of male and female inmates. However, the level of dissociative symptoms was not higher for convicted sex offenders than found in the general population. In contrast, Snow, Beckman and Brack (1996) found that dissociative experiences were higher in their incarcerated sample than among the general public.

Thus, although violent offenders and sexually violent offenders generally score higher in dissociation, none of the above studies examined the role of dissociation as a predictor of physical or sexual violence, and its potential role as a predictor of violence is not known.

Emotional Flooding and Numbing

Emotional flooding and numbing may contribute to revictimization in that floods of fear or other emotions that may occur when confronted with threatening situations can impede cognitive appraisal and fight or flight responses. Numbing or emotional shutdown can effectively result in an inhibition of activity, such as running away or fighting (Cloitre, 1998). Depression in the form of learned helplessness may prevent escape from threatening situations (Peterson & Seligman, 1983).
Revictimized adults tend to report higher arousal in the form of anxiety than those not revictimized (Cloitre, Scarvalone, & Difede, 1997; Messman-Moore, Long, & Siegfried, 2000; however, see. Gidycz, Hanson, & Layman, 1995 for discrepant findings). In their prospective study, Gidycz, Coble, Latham, and Layman (1993) found that anxiety and depression measured at baseline predicted subsequent sexual revictimization within the next academic quarter, and the symptoms measured at the end of the academic quarter (after the revictimization) were exacerbated by the revictimization. Emotional arousal in the form of anxiety may act to impair effective coping (e.g., fight or flee) when faced with danger. Elevated levels of anxiety and depression have also been found in spousal abusers (Dutton 1995).

Individuals may "over-modulate" affect by using cognitive suppression or avoidance to keep certain information from awareness (e.g., see Briere, 2002b; Wegner & Erbner, 1992). The exclusion of such information from conscious awareness may prevent the elicitation of associated or conditioned affect (Briere, 2002b). It stands to reason that such exclusion could thus contribute to emotional numbing and result in emotional and behavioral shutdown when confronted with threat. Field et al. (2001), using a modified Stroop task, found that revictimized women showed stronger Stroop interference to words that were associated to sexual trauma, suggesting cognitive processing interference to trauma-related stimuli. Wilson et al. (1999) found that revictimized women with PTSD waited significantly longer during an experimental date-rape scenario to take appropriate action (i.e., identify the situation as high risk). The women with
longer response latencies had lower mean baseline posttraumatic hyperarousal when compared to those who were not revictimized and who had shorter response latencies. These findings provide some support for the view that revictimized women evidence impairments in the effective management of risky situations and that the impairments are based in cognitive interference and emotional numbing/shutdown, rather than increased arousal.

Alexithymia and Somatization

Alexithymia refers to the inability to identify and express emotional states verbally. It is thought that chronic arousal impairs the individual’s ability to identify what s/he is feeling and to distinguish between different feeling states. As noted, alexithymia refers to the inability to identify and express emotions, and Cloitre et al. (1997) and Zeitlin et al. (1993) found that revictimized women had higher alexithymia scores than non-revictimized women. Although Cloitre (1998) did not specifically include somatization under affect dysregulation, I am including it here insofar as it is related to alexithymia. Krystal (1978) posits that when individuals are unable to identify and express emotions, the emotions find expression through somatic symptoms. Somatization was found to correlate with revictimization in one study that examined somatization (Cloitre, Scarvalone, & Difede, 1997); however, it has never been examined as a predictor of revictimization.

A construct that is related to both somatization and dissociation is “somatoform dissociation” (Nijenhuis, 1999). Somatoform dissociation refers to intrusive physical sensations (e.g., chronic pain that is not due to a known
medical disorder) and numbing symptoms (e.g., freezing/paralysis; inability to speak) that have been empirically related in several studies to childhood sexual abuse and to dissociation (Nijenhuis, 2000; Nihenhuis, Spinhoven, Van Dyck, Van der Hart, & Vanderlinden, 1998; Nijenhuis, Van Engen, Kusters, & Van der Hart, 2001). Based on studies that have examined animal defenses when under attack, Nijenhuis and colleagues relate symptoms of somatoform dissociation to innate fight, flight, and freeze responses (Nijenhuis, Spinhoven, Vanderlinden, Van Dyck, & Van der Hart, 1998; Nijenhuis, Vanderlinden, & Spinhoven, 1998). It is reasonable to posit that symptoms of somatoform dissociation are related to revictimization of adult abuse survivors.

Substance Abuse

Research shows that traumatized individuals are at increased risk of substance abuse disorders such that they abuse substances in order to numb feelings relating to traumatization (Briere, 2001). Intoxication with substances may impair the individual's judgment of risky situations, thereby increasing risk of revictimization (Chu, 1992; Van der Kolk, 1989). In addition, intoxication may function to evoke trauma-related anger and disinhibit any behavioral controls, thereby increasing the risk of behavioral re-enactments, such as perpetration.

Although alcohol consumption was found to correlate with sexual revictimization in one study (Collins, 1998), it failed to predict significantly in two others (Gidycz et al., 1995; Mayall & Gold, 1995). I am not aware of any studies that have investigated substance abuse as a risk factor for physical revictimization.
Research has shown that substance abuse is a proximal risk factor for criminality for both males and females (Gilgun, Klein, & Pranis, 2000). Risk of intimate partner violence is increased when the perpetrator has engaged in substance use (see Willson et al., 2000), and risk of rape/sexual assault is increased with offender alcohol use (Abbey, McAuslan, Zawacki, Clinton, & Buck, 2001; Abracen, Looman, & Anderson, 2000; Breckman & Ullman, 2001).

Interpersonal Relatedness Difficulties

Cloitre (1998) and others (e.g., Briere, 2002b; Van der Kolk et al., 1996) have noted that childhood maltreatment and corresponding attachment difficulties are associated with maladaptive relationship or self schemas in adulthood. These schemata may be associated with various cognitions and behaviors that increase risk of both revictimization and perpetration.

In this section, I include empirical research that has examined interpersonal relatedness per se, as well as variables that are implicated in interpersonal functioning (e.g., self-esteem, attributional style, etc.). It is conceivable that individuals who have negative perceptions and feelings about themselves may be vulnerable to revictimization experiences, particularly when conditioned to believe that they are responsible for abuse or are undeserving of care and respect.

Interpersonal Relatedness and Revictimization

Self-esteem impairments are correlated with revictimization (Collins, 1998) and were found to mediate childhood abuse and revictimization (Drauker, 1997); however, self-esteem did not directly predict revictimization in two studies.
(Collins, 1998; Mandoki & Burkhart, 1989). Similarly, 'Silencing the Self' did not relate to revictimization in two studies (Arata & Lindman, 2002; Banyard, Arnold, & Smith, 2000). On the other hand, self-blame and/or shame was related to revictimization in two of three studies (Arata, 2000; Kellog & Hoffman, 1997; however, see Mandoki & Burkhart, 1989 for discrepant findings). In general, the instruments used in these studies had not been developed with trauma survivors in mind. As such, instruments that assess for self-impairments associated with abuse traumas could be better suited for assessing the role of self-perception in revictimization of those who have experienced childhood abuse.

Hostility and interpersonal sensitivity are correlated with revictimization (Messman-Moore, Long, & Siegfried, 2000), as are interpersonal difficulties (Classen et al., 2001; Cloitre, Scarvalone, & Difede, 1997); however interpersonal difficulties did not predict sexual revictimization with a sample of students (Gidycz et al., 1995). Some research has examined the role of health-risky behaviors in risk of revictimization, and there is some support for the number of sexual partners as relating to revictimization (e.g., Merrill et al., 1999). It is possible that children who are sexually abused learn to associate attachment with sexual activity, thereby increasing the chance that they will engage in sexual activity to obtain or maintain attachments. It is also possible that sexually abused children experience "traumatic sexualization" (Finkelhor, 1987), wherein they learn from a young age to view themselves as sexual objects and to behave accordingly. I have included health-risky behaviors under interpersonal relatedness insofar as sexual risk-taking behaviors are an aspect of interpersonal
relatedness that may function to expose individuals to a greater number of potential perpetrators. Overall, there is a relative paucity of research that has examined the role of interpersonal relatedness and revictimization, and firm conclusions cannot be drawn from the literature to date.

*Interpersonal Relatedness and Perpetration*

Several studies have reported that sex offenders and violent offenders evidence attachment disruptions (Dutton, Saunders, Starzomski, & Bartholomew, 1994; Lightfoot & Evans, 2000; Smallbone & Dadds, 1998, 2000; Smallbone & McCabe, 2003; Ward et al., 2001) and attachment schemas are believed to play a role in interpersonal relatedness (Bowlby, 1983). Although one study found no differences in attachment styles between sex offenders and non-sex offenders (Marshall et al., 2000), juvenile sex offenders were found to be less likely to utilize attachment relationships to cope when under high levels of emotional arousal, and they frequently reported that they experienced high emotional arousal immediately before their sexual offending. Child molesters were reported to use more emotion-focused coping in two studies (Marshall et al., 1999, 2000). Maladaptive attachment styles based in childhood maltreatment may affect how offenders cope with affective arousal and how they modulate that arousal. Adult male spousal abusers who were referred for treatment were found to have higher fearful attachment, and those with higher fearful attachment scores were higher in Borderline Personality traits and chronic anger, jealousy, and trauma symptoms (Dutton et al., 1994). In essence, there is empirical support for the view that offenders evidence significant deficits in interpersonal relatedness,
which appear to relate to childhood experiences (including attachment disruptions) and deficits in affect modulation. Known violent and sexual offenders appear to cope with distress by engaging in physical and/or or sexual violence.

In a related vein, violent offenders and sex offenders tend to evidence impaired self-capacities and psychological disturbance, including empathy deficits (Craissatti et al., 2002; Dutton, 1998; Marshall et al., 1997; McGrath et al, 2000), intimacy deficits (Bumby & Hansen, 1997; Marshall et al., 1997), self-esteem problems (Marshall et al., 1997, 1999), higher hostility, sexual deviance, sexual dysfunction and poor coping (Craissatti et al., 2002), more personality disorders (e.g., Green & Kaplan, 1994; Hare, 1990), and dissociation (Dutton, 1998; Simoneti et al., 2000). These studies are largely correlational studies and none has, to my knowledge, examined abuse-related impaired affect regulation and other symptoms with interpersonal relatedness as overt predictors of violence or sexual violence. The main exception would be the research on Hare’s Psychopathy Checklist, Revised (PCL-R), which reports that PCL-R scores are robust predictors of general criminality and physical violence; however, there is little published evidence that PCL-R scores predict sexual violence (Dietrich, Smiley, & Frederick, submitted). Moreover, Hare (1991) does not view psychopathy as having its origins in childhood abuse, but views it as an innate predisposition.

Sex offenders and violent offenders tend to engage in various cognitive distortions that appear to function to protect the offender from the reality of his/her behaviors (Abbey et al., 2001; Dutton, 1998; Hanson, Grizzarelli, & Scott,
1994; Hayashino, Wurtele, & Klebe, 1995; Johnson & Knight, 2000; Marolla & Scully, 1986; Reitzel-Jaffe & Wolfe, 2001; Stermac & Segal, 1989; Veach, 1997; Ward, Hudson, Johnston, & Marshall, 1997). Such distortions include finding reasons to blame the victim or hold the victim responsible, such as holding misogynistic beliefs (Johnson & Knight, 2000), and negative beliefs and misperceptions about violence (Abbey et al., 2001; Reitzel-Jaffe & Wolfe, 2001). In addition, sex offenders are more likely than non-sex offenders and control groups to deny negative self-characteristics, including negative sexual attitudes and beliefs (McGrath et al., 2000). These beliefs tend to be opposite to those of victims, who frequently blame themselves for the abuse, are self-critical, and view themselves as helpless and the future as hopeless (Briere, 2000). Since offenders tend to project blame and responsibility, the “victim” types of cognitive distortions identified by Briere (2000) would not be expected to relate to perpetration, and are hypothesized to not predict perpetration.

Posttraumatic Stress Disorder

As noted by Cloitre (1998), individuals who have experienced a past traumatic event are at increased risk of experiencing future traumatic events compared to individuals who have never been traumatized. She also points out that CSA and PTSD are highly related, and PTSD has been shown to contribute to risk for repeated victimization of sexual assault victims (see Cloitre, 1998). Symptoms of PTSD may contribute to revictimization in various ways. Avoidance symptoms may function in a manner akin to dissociation (insofar as they function to keep painful or threatening material outside of current awareness), and
hyperarousal symptoms may interfere with cognitive recognition and/or appropriate reactions to danger cues (van der Kolk, 1989). Some have argued that re-experiencing symptoms may increase risk of revictimization by way of a "repetition compulsion" (Noll et al., in press; van der Kolk, 1989), wherein the individual nonconsciously re-enacts the trauma in an attempt to gain mastery. This concept is, however, resistant to operational definition and empirical study.

Symptoms of posttraumatic stress and PTSD itself are reported to be higher for individuals in revictimized groups compared to those with past abuse histories who are not revictimized and compared to those with no interpersonal victimization history (Arata, 1999; Koverola, Proulx, Battle and Hanna, 1996; Messman-Moore, Long, & Siegfried, 2000; Noll et al., in press; Wilson et al., 1999). Cloitre et al. (1997), however, found no differences in PTSD for those who were revictimized compared to those who were assaulted once during adulthood. PTSD predicted revictimization in one study (Arata, 2000), and moderated in another (Sandberg et al., 1999). PTSD hyperarousal was negatively correlated with response latencies in an experimental date-rape situation (Wilson et al., 1999), suggesting that the individuals who experienced an initial inhibited response (hypoarousal) were less likely to stop an inappropriate scenario prior to its escalating to date-rape.

With regard to offenders, symptoms of PTSD are reported in offenders (e.g., Barnard et al., 1992; Burton et al., 1994; Carrion & Steiner, 2000), including men who engage in spousal violence (Dutton, 1998). To my
knowledge, PTSD has never been examined as an overt predictor of violence or sexual violence.

PTSD was measured in divergent ways in the studies, thereby limiting the conclusiveness of the findings with regard to PTSD. The measures used in some of the studies did not measure full PTSD criteria, thereby limiting the conclusions that can be drawn in terms of PTSD criteria as a predictor of revictimization. Some studies used measures that were modified in various ways to be consistent with the current DSM definition of PTSD, and the modifications may have resulted in changes in the psychometric properties of the instruments. Thus, there is the issue of potential reduced reliability and validity with some studies, and thus discrepancies in outcome.

Summary and Conclusions

In summary, problematic affect regulation is empirically associated with revictimization and with perpetration; however, less is known about its predictive validity. Dissociation appears to play a role in physical revictimization, but is not clearly predictive of sexual revictimization. Variations in the studies may be based, in part, on the measurement instruments used to assess different conceptions of dissociation, as well as other methodological issues (discussed below). No published studies (with the exception of Dutton, Starzomski & Ryan, 1996) have examined dissociation as a predictor of perpetration; however, it is correlated with childhood maltreatment and appears to be higher in sexual and violent offenders. Revictimized groups tend to report higher anxiety, and anxiety and depression predicted revictimization and were exacerbated by it in one
prospective study (Gidycz, Coble, Latham, & Layman, 1993). There is also evidence of higher cognitive interference and impaired reactions for revictimized groups when presented with trauma-related stimuli. Somatization has also been shown to correlate with revictimization; however, neither somatization nor somatoform dissociation have been examined as predictors. Substance abuse appears to relate more to perpetration than to revictimization. In general, the above findings provide support for the role of affect dysregulation in revictimization and perpetration. Variations in the findings appear to be due partially to the measurement instruments used to define the constructs. In addition, several researchers have not conducted analyses to determine if postulated affect dysregulation risk factors play a predictive role.

The role of self-perceptions (e.g., self-esteem; self-silencing, attributions) and interpersonal relatedness difficulties in revictimization are likewise equivocal. The majority of researchers used generic measures, rather than measures that were specifically designed to assess for self-perceptions and relational functioning of individuals with childhood maltreatment histories. With perpetrators, correlational studies provide support for impaired attachments, self-perceptions, and interpersonal relatedness; however, no studies to my knowledge have examined the role of self-perceptions as overt predictors of offending behavior. Offenders also tend to engage in significant cognitive distortions, including blaming their victims, misogyny, pro-violence attitudes, and they tend to deny self-problems. These types of cognitive distortions differ from those that are frequently observed in victims of childhood abuse, such as self-
blame, shame, and so forth (Briere, 2000; Owens, 2001). It is thus reasonable to conclude that the types of cognitive distortions that victims engage in will differ from those who perpetrate against others as adults. As with the research on affect dysregulation, many of these studies did not utilize measures that were specifically tied to trauma.

Several studies have reported higher rates of PTSD in those who have been revictimized. Few studies have examined the role of PTSD as a predictor of revictimization. PTSD was found to predict sexual revictimization in one study, and moderated childhood abuse and sexual revictimization in another. Several researchers who examined posttraumatic symptoms did not use measures that assess for full PTSD criteria, and thus the generalizability of their findings is more limited. There are additional methodological issues that may have impacted the divergent findings in some of the above studies.

Methodological Issues

A recent meta-analysis has shown that the wide variation in reported rates of revictimization is influenced by variations in study design and methodology, including discontinuity of assessment type over time, various definitions of child abuse (e.g., contact versus noncontact sexual abuse), variations in age and race of sample, and sample type (college samples show significantly smaller effect sizes than other samples) (Roodman & Clum, 2001).

Such heterogeneity is evident in the above studies, and likely contributes to the mixed findings in terms of rates of revictimization and predictors of revictimization. The mean reported age of the students in the studies reviewed
for this chapter is 20.03, as compared to a mean age of 27.93 for the
clinical/community samples. Thus, the students were quite young when assessed
for revictimization, which may result in lowered base rates of revictimization and
reduced power to detect effects. With older samples there is more time in which
to be potentially revictimized, such that rates of revictimization would likely be
higher over time for older individuals. Lower baserates with younger samples
could result in false null effects.

The definitions of CSA vary, with some researchers including non-contact
forms of CSA, some excluding incest, and several using different upper age limits
to define CSA, with reported ages ranging from 14 to 18. Rates of CSA in student
samples range from 7% to 59% for those studies with control groups (i.e.,
samples that were not composed solely of CSA survivors), and from 9% to 71%
in clinical/community samples. Some researchers include certain actions as CSA
(e.g., non contact forms of abuse, such as exposure of genitals), whereas in
other studies those individuals who experienced those events would be placed in
a control group, thereby possibly confounding the results. As noted, one problem
related to this heterogeneity is the problem of low base rates-- the more
stringent the definition of CSA, the lower the base rates and the less predictive
power. Similarly, the more stringent the definition is of revictimization, the lower
the base rates. The above studies vary in the definition of "adulthood." Several
studies include teenagers aged 14 and up as adults, whereas in other studies
these individuals would be categorized as belonging in the CSA group.
The Current Study

In this study, I examined the predictive role of affect dysregulation, interpersonal difficulties, and PTSD in revictimization. Several different indices of dissociation, including peritraumatic dissociation, trauma-specific dissociation, clinical (state/trait) dissociation, and somatoform dissociation were used in this study. Somatoform dissociation had never been studied as a risk factor for revictimization. In addition to dissociation, the predictive role of substance abuse, self-perceptions, and relationship functioning were examined; however, the measures chosen for this study were developed to be trauma-specific measures, specifically related to childhood maltreatment trauma. In addition, most of the measures are normed and standardized (with the exception of the SIDES-SR).

I sampled from populations that have not heretofore been utilized in risk of revictimization studies. In addition to a clinical sample, male and female inmates and trauma survivors that utilize the internet for trauma-related support were recruited. I utilized a broad definition of childhood abuse (up to age 18) and assessed for several different types of childhood abuse. In addition, I assessed for several different types of revictimization, and included revictimization by an intimate partner.

With regard to offender samples, there have been few predictive studies that have examined the role of post childhood maltreatment sequelae as predictors of interpersonal perpetration. This investigator also examined the predictive ability of various factors in terms of perpetration of physical and sexual violence.
The research questions can be stated explicitly as follows: First, do affect dysregulation, interpersonal relatedness problems, and PTSD variables increase the risk of physical and/or sexual revictimization and of revictimization within intimate partnerships, over and above any effects of demographics and childhood maltreatment? It was hypothesized that PTSD (as measured by the DAPS PTSD scale), various types of dissociation (DAPS Trauma-Specific Dissociation scale and Peritraumatic Dissociation scale; Multiscale Dissociation Inventory total scale score; Somatoform Dissociation Questionnaire total scale score), substance abuse (DAPS substance abuse scale) cognitive distortions (Cognitive Distortions Scales total score), and impaired self capacities (Impaired Self Capacities Scale total score) would predict revictimization of adults with childhood abuse histories. Since these variables show conceptual similarities to the C-PTSD construct, a second subsidiary hypothesis was that C-PTSD (as measured by the DAPS PTSD scale and the SIDES-SR total score) would predict revictimization independently of these scales (DAPS dissociation and substance abuse scales, MDI, SDQ-20, CDS, IASC) in separate regression analyses.

With regard to perpetration, the main research question was whether dynamic posttraumatic variables increase the risk of perpetration of physical or sexual violence over and above any effects of demographic and childhood maltreatment variables. Specifically, it was hypothesized that PTSD (per the DAPS PTSD scale), various types of dissociation (DAPS Trauma-Specific Dissociation scale and Peritraumatic Dissociation scale; Multiscale Dissociation Inventory total scale score; Somatoform Dissociation Questionnaire total scale score; Somatoform Dissociation Questionnaire total scale score)
score), impaired self capacities (Impaired Self Capacities Scale total score), C-PTSD, and substance abuse (DAPS substance abuse scale) would predict physical and sexual perpetration. The victim-types of cognitive distortions per the CDS were hypothesized to not predict perpetration.
Chapter 3. Method

Study Design

The design for this study is correlational (i.e., regression analysis), using non-random sampling (convenience samples). The design includes retrospective, self-report measures of childhood maltreatment, posttraumatic and associated feature sequelae, and cognitive distortions as independent variables, and self-reports of adulthood revictimization/perpetration as the dependent variables. In addition, official legal records are coded for the correctional samples to record perpetration (sexual and/or physical violence).

Participants and Procedures

Two hundred and twenty-four volunteers (135 females; 87 males; 2 individuals did not indicate gender) were recruited by way of written advertisement (see Appendix A) from clinical populations, including 19 persons from a local Community Counseling Center (NWCC) (8.5%), 72 from Canada Corrections (32.1%), 38 from a Correctional Center for Women (BCCW) (17%), as well as 95 from the Internet (42.4%). Seventeen individuals did not meet childhood maltreatment criteria per the CMIS, and were dropped from the study, leaving a total sample size of 207. Of the remaining sample, 130 were female (62.8%) and 76 were male (36.7%). One person did not indicate gender. The majority (96) of individuals from the internet and clinic sample were female. The breakdown per group for men and women from the sample of 207 is as follows: 63 male inmates; 34 female inmates; nine men and 82 women from the internet; and 14 women and four men from the clinic (76 males and 130 females in total).
The participants ranged in age from 18 years to 65 years and the mean age for the sample was 37.9 ($SD = 10.2$). The majority was Caucasian (85.5%), followed by Aboriginal (9.7%), Hispanic (1.4%), and Black, Asian or Other (1% respectively). Exclusionary criteria included individuals under the age of 18, individuals who did not report child abuse experiences, individuals who did not understand English, and individuals who did not give informed consent.

Approval was obtained by all relevant institutional review boards, including the University of British Columbia, the Correctional Service of Canada and the Ministry of Public Safety and Solicitor General. All participants were provided with a package of self-report measures (described below) and a brief demographics information sheet (Appendix B). The Community and Internet participants were offered $20 to compensate for the time required to complete the questionnaires, and individuals from the correctional facilities were offered a $7 honorarium (the equivalent to one day's pay in the federal Correctional system), in accordance with Correctional policy. Several of the respondents from the Internet sample declined the honorarium. Their funds were pooled and sent to The United Way International, designated for survivors and families of victims of the 9-1-1 terrorist attacks against the United States, which occurred at the time of data collection.

All respondents were informed that they would be identified only by code number, and were told to not write their names on any of the materials. The inmates were recruited by written notice (posted in the common areas of the women's prison; sent to individual cells in the men's prison). Notices were posted
at various locations at the Community Clinic, interested clients obtained the
questionnaire package and $20 cash from the clinic receptionist, and the
questionnaires were returned to the receptionist. Notices were also posted on the
Internet, including various email discussion lists for survivors of trauma, email
discussion lists for professionals who work with trauma survivors, and internet
sites specifically related to trauma. Interested participants contacted me by way
of email, and the package of materials was sent to them either as an email
attachment, or through the regular mail system. Professionals from the
professional email discussion lists also requested questionnaire packages for their
individual clients who wanted to participate in the study.

When completed questionnaires were returned to me via email, the
questionnaires were immediately printed out from the computer, the honorarium
was sent to the address specified in the email, and the email message (including
all identifying information) was deleted from the computer. To insure that
individuals did not complete the questionnaire more than once using different
email addresses, their postal codes were recorded and checked for redundancy.
When questionnaires were returned through the regular mail system, the names
and mailing addresses of the participants were destroyed as soon as the
honorarium was sent.

With the correctional inmates, the code on the questionnaire package was
recorded, along with their legal identification number (so that they could receive
payment through the Institution, and so that acts of perpetration could be coded
from their files). These records were kept in a locked filing cabinet separate from
the questionnaires, such that the questionnaires could not be connected to the legal identification number or the information from legal files. The money for the honoraria was given to institutional authorities, along with a list of names of who was to get paid. The list of names was destroyed once the inmates received their payment. After I coded the relevant legal information from the inmate files with regard to acts of violence and/or sexual violence against others, the coded information was kept with the associated questionnaires, with no identifying information. The original records with the code number and legal identification number were destroyed, so that the identification of the inmates cannot be traced.

All participants were informed that they could withdraw from participation at any time with no adverse consequences and were provided with contact information for the researcher in case they had any questions, as well as numbers to crisis lines and counseling centers if they wished to discuss any thoughts or feelings that came about from participating in the study (Appendix C). Correctional inmates were informed that that could contact the duty psychologist if they experienced any distress after completing the questionnaires. All correctional inmates signed informed consent forms (Appendix D), and the community and Internet samples were advised that completion and return of the questionnaire indicated consent (Appendix D).

**Instruments**

The participants completed several self-report instruments, including those that inquired into types of traumatic events and posttraumatic symptoms
(Detailed Assessment of Posttraumatic Stress), associated features to PTSD (Cognitive Distortions Scales, Multiscale Dissociation Inventory, Inventory of Altered Self Capacities, Self-Inventory for Disorders of Extreme Stress, and Somatoform Dissociation Questionnaire), types of childhood maltreatment, revictimization during adulthood, and perpetration during adulthood.

**Detailed Assessment of Adult Posttraumatic Stress (DAPS).** The DAPS (Briere, 2001) is a 104-item self-report, standardized instrument that assesses the full range of DSM-IV criteria for PTSD and peritraumatic dissociation, as well as three associated features: Trauma-specific dissociation, suicidality and substance abuse. The DAPS includes two validity scales. All clinical scales have good reliability, with alpha ranging from .81 to .90 for the trauma specification scales and .72 to .96 for the clinical scales (Briere, 1998; 2001). The scales also have good validity, good diagnostic sensitivity (.88; ability to correctly identify persons with PTSD), and good diagnostic specificity (.86; ability to correctly identify those without PTSD). It has been normed on over 400 persons from the general population who had experienced at least one traumatic event during their lives. The mean alpha reliability coefficients range from .77 to .92, with good reported validity (Briere, 2001).

**Multiscale Dissociation Inventory (MDI).** The MDI (Briere, 2002a) is a 30-item instrument designed to measure DSM-IV-TR dissociative symptoms, including disengagement (the experience of being detached from the environment, such as being "spaced out"), depersonalization (the sense that one's body or parts of one body are alien or foreign), derealization (the sense
that one's external environment is not quite real -- for example, as though one were dreaming), emotional constriction (blunted affect), memory disturbance (amnesias), and identity dissociation (as with dissociated identities). The MDI was normed on over 400 individuals from the general population who experienced at least one traumatic event during their lifetimes. Reported mean reliability (internal consistency) coefficients are .85 for the general population sample, .77 for a university sample, and .92 for a clinical-community sample. The instrument has good reported validity (Briere, 2002a).

*Cognitive Distortion Scales (CDS).* The CDS (Briere, 2000) is a 40-item instrument that assesses five types of cognitive distortions that have been reported in persons who have been maltreated as children. These include self-criticism, self-blame, helplessness, hopelessness, and preoccupation with danger. The self-criticism (SC) scale measures low self-esteem and self-devaluation, with high scores reflecting a view of self as intrinsically bad, unattractive, unintelligent, or unacceptable. The self-blame scale (SB) measures self-blame for negative, unwanted events that the individual has experienced, including events that were beyond the person's control. The helplessness (HLP) scale is a measure of perceptions of being unable to control important aspects of one's life and belief that efforts to do so will not be successful. This belief may lead to passivity in the face of danger. The hopelessness (HOP) scale measures beliefs that the future is bleak and that one will suffer or fail. The preoccupation with danger (PWD) scale measures the tendency to view the world and other people as dangerous, and that neutral circumstances will result in negative outcomes. It
has norms available for over 600 people from the general population. Internal consistency coefficients for the CDS clinical scales range from .89 to .97, with an overall mean CDS scale alpha of .93 for the general normative sample. The CDS also has good reported validity (Briere, 2000).

*Inventory of Altered Self Capacities (IASC).* The IASC (Briere, 1998, 2000) is a seven-scale, 63-item instrument that assesses for impairments in sense of self that are frequently reported in adults who experienced chronic and severe abuse and neglect. The items reflect symptoms and behaviors that have traditionally been associated with Borderline Personality Disorder, and include difficulties in relatedness, identity, and affect regulation. The seven scales assess Interpersonal Conflicts, Idealization-Disillusionment, Abandonment Concerns, Identity Impairment, Susceptibility to Influence, Affect Dysregulation, and Tension Reduction Activities. The instrument was normed on the same subjects as the CDS (above). Internal consistency alphas range from .87 to .96, and reported validity is good (Briere, 1998, 2000).

*Somatoform Dissociation Questionnaire (SDQ-20).* The SDQ-20 (Nijenhuis, 1996) is a 20-item instrument that assesses for Somatoform Dissociation, with items rated on a scale from 1 (Not at all) to 5 (Extremely). It has reported internal consistency reliability of .95, and the author provides evidence for convergent, discriminant, and predictive validity (Nijenhuis, 1996). The items of the SDQ-20 reflect somatic (sensory and motor) aspects of dissociation that are not included among the DSM-IV dissociative disorders criteria (although they are included in the tenth edition of the International Classification of Diseases by the
World Health Organization). These items are traditionally associated with symptoms of conversion hysteria. Normative data are available for Dutch, Turkish and North American clinical samples, with subjects who were diagnosed with dissociative disorders, somatoform disorders, epilepsy, eating disorders, anxiety disorders, major depressive disorder, and bipolar disorder.

*Self-Inventory of Disorders of Extreme Stress (SIDES-SR).* The SIDES-SR (van der Kolk, unpublished) is a 45-item self-report measure designed to assess for associated features to PTSD. The measure includes six scales, including affect dysregulation, amnesia/dissociation, alterations in sense of self, altered relationships, somatization, and altered systems of meaning. The interview format (SIDES), upon which the SIDES-SR is based, was used for the original DSM-IV field trial. The results were incorporated into the Associated Features to PTSD section of the DSM-IV (American Psychiatric Association, 1994). The researchers for the field trial examined the empirical literature and compiled 54 problems that were reported in studies on childhood maltreatment. These 54 problems were compiled into seven clusters that were arranged into seven scales in an interview format for the DSM-IV field trial (SIDES). The scales of the interview evidenced good internal consistency (.76-.90) (Alterations in Perceptions of the Perpetrator scale was dropped due to low reliability) (Pelcovitz, van der Kolk, Roth et al., 1997). The PTSD field trial researchers reported high correlations between the SIDES and measures of PTSD for interpersonal violence survivors as compared to disaster-only survivors. These results suggested that Complex PTSD/DESNOS is a homogeneous construct that
captured a wide array of symptoms, which, although scattered throughout the DSM, appeared to have as a common base their etiology in severe, interpersonal traumatic events. Reliability coefficients for the modified SIDES-SR total scale are reported at .93 and from .74 to .82 for five subscales. The Somatization subscale coefficient was somewhat lower, at .68 (Luxenberg, Spinazzola, & van der Kolk, 2001). There are currently no validity data available on the SIDES-SR.

*Child Maltreatment Interview Schedule (CMIS).* The CMIS (Briere, 1992a) was administered in self-report format, and inquires into childhood psychological, physical, and sexual abuse, as well as parental physical and psychological unavailability, parental substance abuse, and witnessing domestic violence. Information on these experiences was obtained for children and adolescents up to the age of 18. The CMIS inquires into maltreatment before the age of 17; however, I included the age of 17 since adult victimization is defined as victimization at age 18 and older. Seventeen was included as childhood abuse so as to not leave the one year between age 17 and 18 unaccounted for in terms of victimization experiences and so that it allows for higher baserates of childhood abuse. It is also consistent with other research studies (e.g., Cloitre, Scarvalone, & Difede, 1997). Respondents were also asked if they perceived their experiences to be abuse. The psychological abuse subscale has good alpha reliability (.87) (Briere & Runtz, 1988; 1990). There are no reliability or validity data on the remaining scales, since the items simply ask about potential maltreatment experiences and do not sum to form scales. The CMIS was chosen because it includes all forms of maltreatment and parental variables, whereas
other instruments tend to assess for only certain types of abuse. This measure also includes the participants' perceptions of whether or not what they experienced was abusive. Although there are no validity data on the CMIS (other than internal consistency coefficients for the psychological abuse scale), the CMIS has been successfully used in several credible studies (for example, Cloitre, Cohen, Edelman, & Han, 2001; Cloitre, Scarvalone, & Difede, 1997; Heffernan & Cloitre, 2000; Walker et al., 1997; Walker, Newman, Koss, & Bernstein, 1997).

All of the following forms of childhood adversity are measured by the CMIS, with the exception of loss of a caregiver during childhood. For the latter rating, I included a question inquiring into whether the individual had ever been separated from a primary caregiver prior to age 17, the identity of the caregiver(s), and the age(s) of separation.

In addition to coding each type of maltreatment as “present” or “absent,” I weighted each of the following childhood maltreatment types to obtain severity ratings for each type of maltreatment. Weights were determined in accordance with the clinical and empirical literature regarding those characteristics of childhood maltreatment that have been reported to result in greater impairment, such as frequency of abuse, duration, chronicity, severity (e.g., whether medical attention was required), number of perpetrators, and for sexual abuse, intrafamilial abuse.

*Parental substance abuse* included items that identified a parent or surrogate parent as having problems with drugs or alcohol that led to medical problems, divorce or separation, being fired from work, or arrest for impaired
driving or public intoxication. Information on duration of parental substance abuse was also obtained. For severity ratings, the presence of parental substance abuse was multiplied by "2" if the duration of the substance abuse exceeded one year (chronicity). The highest rating possible is 2 (high severity). Those whose caregivers abused substances for less than a year received a rating of 1 (low severity), and those who did not have caregivers who abused substances received a rating of 0.

*Witnessing parental violence* included witnessing one parent hit or beat up the other parent. Information was also obtained on frequency of parental violence and whether it resulted in medical aid or contact of authorities. Witnessing parental violence was coded as a dichotomous variable, and a severity index was calculated as follows: If both parents engaged in physical violence toward each other, a score of 2 was given. If medical attention was required or authorities were contacted, a score of two was given, and if frequency was more than once, a score of 2 was given. The total possible score is 6. To ensure that severity ratings across *types of abuse* are on similar scales, the rating that was obtained by more than 50% of those who witnessed abuse was used as the cutoff score. Those who scored at or above the cutoff received a severity rating of 2 (high severity), and those below the cutoff received a weight of 1 (low severity). Those who did not witness parental violence received a severity rating of 0. The median score at which a severity rating of two was given was "5".
To measure feelings of *Emotional Neglect*, participants were asked to rate how much they felt their parents loved and cared about them, on a scale from 1 (Not at all) to 4 (Very much). Ratings were obtained for each parent and for two different age groups (0-7; 8-17). Mean ratings were computed, and individuals were dichotomously coded as "felt unloved" if their mean score across parents and age groups was less than 2. For severity ratings, the individual raw scores were reversed (e.g., a rating of 4 was coded as 1, a rating of 3 was coded as 2, a rating of 2 was coded as 3, and a rating of 1 was coded as 4), and mean ratings were obtained. Those whose mean rating scored at or above the 50% cutoff were given a severity rating of 2 (high) for feeling unloved. Those below the median were given a 1 (median = 2.5).

To measure *Childhood Psychological Abuse*, participants were asked to rate frequencies of being yelled at, insulted, criticized, made to feel guilty, ridiculed or humiliated, embarrassed in front of others, and made to feel like a bad person, on a scale from 0 (never) to 6 (over 20 times a year). Individuals rated each type of psychological abuse. If an individual reported a rating of "6" for any one type of psychological maltreatment, they were coded as positive for psychological abuse (dichotomous variable). Total psychological abuse scale scores were computed by summing item ratings. For severity, those who scored at or higher than the median total score of 37 were given a score of 2, and those whose score fell below the median were coded as 1.

*Childhood Physical Abuse* (CPA) was defined as a parent or adult caregiver intentionally doing something (like hitting, punching, cutting, or pushing) that
resulted in bruises, scratches, broken bones, or broken teeth. Presence or absence of CPA was computed, as was a severity index. The severity index was calculated by weighting presence of CPA by the number of perpetrators (two or more perpetrators was given a score of 2), the frequency of abuse (2+ times received a score of 2), duration of abuse (more than one year received a score of 2), and whether medical attention had been obtained (score of 2). The highest possible score for CPA is 8. Median scores were calculated, and those whose score fell at or above the median score of 5 received a weighting of 2 (high severity), those who fell below the median received a weighting of 1 (low severity), and those who did not report CPA received a score of 0.

Childhood Sexual Abuse without Penetration (CSA1) was defined as anyone kissing them in a sexual way, or touching their bodies in a sexual way, or making the child touch the perpetrators sexual parts. Individuals were coded positively for CSA1 if it occurred with an individual at least five years older than the child, an older family member, if force was used, or if the individual was unable to give consent. A severity index was computed by weighting presence of CSA1 by the number of different perpetrators (score of 2 for 2+ perpetrators), frequency (score of 2 for 2+ times), duration (longer than one year = 2), use of force (score of 2 if force was used), and intrafamilial abuse (score of 2) for a total possible severity rating of 10. Median splits (rating of 9 in the current sample) were used to divide the weights into high severity and low severity.

Childhood Sexual Abuse with Penetration (CSA2) was defined as anyone having oral, anal or vaginal intercourse with them, or inserting a finger or object
into their anus or vagina. Individuals were coded positively for CSA2 if it occurred with an individual at least five years older than the child, an older family member, if force was used, or if the individual was unable to give consent. A severity index was computed by weighting presence of CSA2 by the number of different perpetrators, frequency, duration, use of force, and intrafamilial perpetrator(s) for a total possible severity rating of 10. Median splits (score of 6) were used to divide the weights into high severity and low severity.

Participants were also asked if they had lost a significant caregiver during childhood, through separation/divorce, death, foster care placement, and illness. Data for the loss variable were coded as dichotomous (yes or no) variables.

To measure the overall experience and severity of childhood maltreatment, I computed a maltreatment index as follows. The number of different types of childhood maltreatment that the individuals experienced was calculated, with a total possible score of "8" (parental substance abuse, witnessing, emotional neglect, psychological abuse, physical abuse, CSA1, CSA2, and loss). The severity ratings for parental substance abuse, witnessing violence, emotional neglect, psychological abuse, physical abuse, and the two forms of sexual abuse were summed (total possible score of 14). This was then added to the number of different types of maltreatment to result in the maltreatment index, with a possible total score of 22.

The Adult Victimization Survey (AVS) is a modified version of the Child Maltreatment Interview Schedule (CMIS) (the AVS is shown in Appendix E) for use in the current study. I re-worded items from the CMIS psychological, physical
and sexual abuse sections such that they are suitable for adult victimization experiences. Respondents were asked to indicate experiences of psychological abuse, physical assault, and sexual assault after age 17. Adult sexual assault was coded positively if the individuals indicated they had experienced the same events as in the CMIS (e.g. sexual kissing, touching, penetration) when they did not want it or when they were too intoxicated with drugs or alcohol to give consent. Items also inquired into the individual's relationship to the perpetrator(s), number of perpetrators, and physical severity (e.g., need for medical attention).

Items from the psychological, sexual and physical abuse sections were reworded to assess perpetration against others (e.g., "after age 17, did you ever hurt anyone so badly that they had to see a doctor or go to the hospital?"). Respondents were also asked to indicate frequency of physical assault, sexual assault, use of force, and relationship to victim.

In addition to the self-report items to assess for perpetration against others, charges and convictions for criminal activities were coded from official legal records for male and female inmates. Physical violence included any charges for assault, assault causing bodily harm, assault with a weapon, aggravated assault, manslaughter, attempted murder, first degree murder, second degree murder, robbery with violence, armed robbery, and arson. Sexual assault included any charges for indecent acts, indecent exposure, sexual activity with a minor, sexual assault, sexual assault with a weapon, aggravated sexual assault, and incest.
Data Screening

Data were screened for missing values and extreme values. Extreme values (z-scores of 3 or higher) were found on the Somatoform Dissociation Questionnaire for 3 individuals; however, perusal of the data showed that there were no data entry errors. Statistical analyses were conducted with the 3 individuals excluded, and no differences in result were found. The extreme values were retained in all analyses so as to accurately reflect the data as sampled from these various populations.

Analyses

Reliability and Validity. Reliability coefficients (Cronbach’s alphas) were computed for the various instruments. Correlations between the SIDES-SR current total and DAPS, MDI, CDS, IASC, and SDQ-20 total scores were also calculated to ascertain convergent validity of the SIDES-SR, and Factor Analysis of the DAPS, MDI, CDS, IASC, SDQ-20, and SIDES-SR was conducted as a test of construct validity.

Descriptive Data. Data on rates of childhood maltreatment, revictimization, and perpetration were calculated, and the subsamples were compared on demographic and childhood maltreatment variables.

Revictimization. Logistic Regression analyses were conducted to test the proposed predictors for two types of adult victimization (physical, sexual) as measured dichotomously, as well as for revictimization by intimate partners. Demographic covariates, childhood abuse types, severity of childhood maltreatment (maltreatment index), PTSD, and the other hypothesized risk factor
variables were entered as predictors in separate hierarchical stepwise logistic regression analyses for each type of revictimization. For victimization by intimate partners, I conducted a separate regression analysis for physical revictimization by a partner, sexual revictimization by a partner, and combined psychological, physical, and sexual revictimization by a partner (as a measure of severity of partner revictimization). Separate regression analyses were conducted for different types of outcome in order to explore whether covariates and predictors vary between different types of revictimization experiences.

Perpetration. Predictors of physical and sexual perpetration were examined with hierarchical logistic regression analysis. Demographic variables, childhood maltreatment variables, and symptom total scores (substance abuse, peri-traumatic dissociation, trauma-specific dissociation, MDI, SDQ-20, CDS, and IASC) were entered in the same manner as the predictors of revictimization. Discriminant function analysis (DFA) was not used to compare perpetrators and non-perpetrators given that DFA assumes multivariate normality and some of the predictors are dichotomous. Two separate regression analyses were run: one for physical perpetration and one for sexual perpetration. The coding for physical perpetration was such that an individual was coded as "positive" for physical perpetration if s/he either self-reported physical perpetration or received criminal charges for perpetration of physical violence. The same coding rationale was used for sexual perpetration.
Chapter 4. Results

The results of analyses on the reliability and validity of the measures in this study are reported in this chapter, as well as the results of regression analyses. After reporting on the reliability and validity data, group differences are examined, and the main research questions are addressed with regression analyses.

Internal Consistency and Validity

Internal Consistency

Cronbach's alpha coefficients to assess internal consistency for each of the measures are shown in Table 3. The total scale reliabilities are excellent, and the subscale alpha coefficients are fair to excellent. The one exception is the SIDES-SR Altered Self-Capacities scale, where the internal consistency coefficient is somewhat low (coefficient of .68).

Table 3

*Cronbach's Alpha Coefficients for Full Sample on all Measures (N = 207)*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Number of Items</th>
<th>Combined Samples</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMIS Psych. Abuse</td>
<td>7</td>
<td>.94</td>
</tr>
<tr>
<td>DAPS Peri-tr. Distress</td>
<td>8</td>
<td>.85</td>
</tr>
<tr>
<td>DAPS Peri-tr. Dissociation</td>
<td>6</td>
<td>.88</td>
</tr>
<tr>
<td>DAPS Reexperiencing</td>
<td>10</td>
<td>.94</td>
</tr>
<tr>
<td>DAPS Avoidance</td>
<td>10</td>
<td>.90</td>
</tr>
<tr>
<td>DAPS Hyperarousal</td>
<td>10</td>
<td>.93</td>
</tr>
<tr>
<td>DAPS Posttraumatic Distress</td>
<td>30</td>
<td>.98</td>
</tr>
<tr>
<td>Measure</td>
<td>N</td>
<td>Reliability</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---</td>
<td>-------------</td>
</tr>
<tr>
<td>DAPS Trauma-specific Dissoc.</td>
<td>4</td>
<td>.89</td>
</tr>
<tr>
<td>DAPS Posttraumatic Impairment</td>
<td>5</td>
<td>.89</td>
</tr>
<tr>
<td>DAPS Substance Abuse</td>
<td>10</td>
<td>.90</td>
</tr>
<tr>
<td>DAPS Suicidality</td>
<td>10</td>
<td>.94</td>
</tr>
<tr>
<td>DAPS Posttraumatic Symptoms Total</td>
<td>30</td>
<td>.97</td>
</tr>
<tr>
<td>MDI Disengagement</td>
<td>5</td>
<td>.87</td>
</tr>
<tr>
<td>MDI Derealization</td>
<td>5</td>
<td>.91</td>
</tr>
<tr>
<td>MDI Depersonalization</td>
<td>5</td>
<td>.91</td>
</tr>
<tr>
<td>MDI Memory Disturbance</td>
<td>5</td>
<td>.89</td>
</tr>
<tr>
<td>MDI Multiplicity</td>
<td>5</td>
<td>.93</td>
</tr>
<tr>
<td>MDI Emotional Constriction</td>
<td>5</td>
<td>.96</td>
</tr>
<tr>
<td>MDI Total</td>
<td>30</td>
<td>.97</td>
</tr>
<tr>
<td>CDS Self-blame</td>
<td>8</td>
<td>.93</td>
</tr>
<tr>
<td>CDS Helplessness</td>
<td>8</td>
<td>.95</td>
</tr>
<tr>
<td>CDS Hopelessness</td>
<td>8</td>
<td>.97</td>
</tr>
<tr>
<td>CDS Preoccupation w/ Danger</td>
<td>8</td>
<td>.92</td>
</tr>
<tr>
<td>CDS Self Criticism</td>
<td>8</td>
<td>.96</td>
</tr>
<tr>
<td>CDS Total</td>
<td>40</td>
<td>.98</td>
</tr>
<tr>
<td>IASC Interpersonal Conflict</td>
<td>9</td>
<td>.93</td>
</tr>
<tr>
<td>IASC Idealization – Disillusionment</td>
<td>9</td>
<td>.95</td>
</tr>
<tr>
<td>IASC Abandonment Concerns</td>
<td>9</td>
<td>.94</td>
</tr>
<tr>
<td>IASC Susceptibility to Influence</td>
<td>9</td>
<td>.96</td>
</tr>
<tr>
<td>IASC Affect Dysregulation</td>
<td>9</td>
<td>.94</td>
</tr>
<tr>
<td>IASC Tension Reduction</td>
<td>9</td>
<td>.87</td>
</tr>
<tr>
<td>IASC Identify Impairment</td>
<td>9</td>
<td>.95</td>
</tr>
<tr>
<td>IASC Total</td>
<td>63</td>
<td>.99</td>
</tr>
<tr>
<td>SIDES-SR Current Affect Dysreg.</td>
<td>19</td>
<td>.93</td>
</tr>
<tr>
<td>SIDES-SR Current Amnesia/Diss.</td>
<td>5</td>
<td>.82</td>
</tr>
<tr>
<td>SIDES-SR Current Self Perceptions</td>
<td>5</td>
<td>.68</td>
</tr>
<tr>
<td>SIDES-SR Current Relationships</td>
<td>6</td>
<td>.79</td>
</tr>
<tr>
<td>Scale</td>
<td>Mean</td>
<td>Alpha</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>SIDES-SR Current Somatization</td>
<td>5</td>
<td>.72</td>
</tr>
<tr>
<td>SIDES-SR Current Meaning</td>
<td>5</td>
<td>.71</td>
</tr>
<tr>
<td>SIDES-SR Current Total</td>
<td>45</td>
<td>.92</td>
</tr>
<tr>
<td>SDQ-20</td>
<td>20</td>
<td>.95</td>
</tr>
<tr>
<td>AVS Psych. Abuse</td>
<td>7</td>
<td>.97</td>
</tr>
</tbody>
</table>

Note. CMIS = Child Maltreatment Interview Schedule; DAPS = Detailed Assessment of Posttraumatic Stress; MDI = Multiscale Dissociation Inventory; CDS = Cognitive Distortions Scales; IASC = Inventory of Altered Self Capacities; SIDES-SR = Self-Inventory for Disorders of Extreme Stress; SDQ020 = Somatoform Dissociation Questionnaire; AVS = Adult Victimization Survey

To discern whether the relatively low alpha coefficient for the SIDES-SR Altered Self-Perceptions scale was due to responses associated with a specific group, the coefficients for male inmates, female inmates, and non-inmates were examined separately. As can be seen in Table 4, the low scale coefficient for Altered Self-Perceptions appears to derive from the male inmates. Descriptive analysis suggests that the low coefficients for the male inmates may be based in a restriction in the range of scores. Male inmates were significantly more likely to provide a rating of zero on the Altered Self-perceptions scale of the SIDES-SR than were the other two groups ($\chi^2 = 36.5, 2, p < .001$), with 39.7% of male inmates completely reporting no alterations in self-perceptions, 20.6% of female inmates reporting no alterations in self-perceptions, and only 3.6% of the clinical/internet group reporting no alterations in self perceptions. It should be noted that the combined clinical/internet group consisted predominantly of females (96 females compared to 13 males). The higher proportion of zero ratings for male inmates may reduce in-group variability and may have deflated the inter-item correlations.
Table 4

*Internal Reliabilities of Groups on Self-Related Subscales*

<table>
<thead>
<tr>
<th>Scale</th>
<th>Combined Samples (n = 207)</th>
<th>Male Inmates (n = 63)</th>
<th>Female Inmates (n = 34)</th>
<th>Non-inmates (n = 110)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS Self Criticism</td>
<td>.96</td>
<td>.92</td>
<td>.96</td>
<td>.94</td>
</tr>
<tr>
<td>SIDES-SR Current Self Perceptions</td>
<td>.68</td>
<td>.66</td>
<td>.82</td>
<td>.77</td>
</tr>
</tbody>
</table>

*Note.* CDS = Cognitive Distortions Scales; SIDES-SR = Self-Inventory for Disorders of Extreme Stress

Also examined in Table 4 are coefficients from a related construct, self-criticism. As can be seen in Table 4, the alpha coefficients for all three groups on self-criticism are excellent, which is interesting considering the lowered values on the SIDES-SR self-perceptions. When looking at the individual items of the SIDES-SR altered self-perceptions scale and the items from the CDS self-criticism scale (Table 5), it becomes apparent that the SIDES-SR measures *feelings of* powerlessness, personal deficiency, guilt, shame, and feeling different from others, whereas the CDS self-criticism scale appears to generally measure *beliefs* about oneself.
Table 5

**Percent endorsement on Items from the Self-Inventory for Disorders of Extreme Stress (SIDES-SR) Self-Perceptions and Cognitive Distortions Scales (CDS) Self-Criticism scale**

<table>
<thead>
<tr>
<th>Item</th>
<th>Male Inmates</th>
<th>Female Inmates</th>
<th>Clinic/Internet</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDES-SR Feeling of No influence in Life</td>
<td>76.2</td>
<td>55.9</td>
<td>48.2</td>
</tr>
<tr>
<td>SIDES-SR Something is Wrong with Me</td>
<td>58.7</td>
<td>41.2</td>
<td>11.8</td>
</tr>
<tr>
<td>SIDES-SR Feel Guilty</td>
<td>60.3</td>
<td>41.2</td>
<td>20.0</td>
</tr>
<tr>
<td>SIDES-SR Feel Ashamed</td>
<td>65.1</td>
<td>44.1</td>
<td>30.0</td>
</tr>
<tr>
<td>SIDES-SR Feel set apart from others</td>
<td>54.0</td>
<td>35.3</td>
<td>18.2</td>
</tr>
<tr>
<td>CDS Hating Yourself</td>
<td>34.9</td>
<td>29.4</td>
<td>12.7</td>
</tr>
<tr>
<td>CDS Criticizing Self</td>
<td>30.2</td>
<td>17.6</td>
<td>0.9</td>
</tr>
<tr>
<td>CDS Calling Self Names</td>
<td>46.0</td>
<td>35.3</td>
<td>19.1</td>
</tr>
<tr>
<td>CDS Not Liking Self</td>
<td>39.7</td>
<td>23.5</td>
<td>9.1</td>
</tr>
<tr>
<td>CDS Feeling Unattractive</td>
<td>38.1</td>
<td>20.6</td>
<td>3.6</td>
</tr>
<tr>
<td>CDS Putting Self Down</td>
<td>38.1</td>
<td>20.6</td>
<td>2.7</td>
</tr>
<tr>
<td>CDS Calling Self Stupid or Ugly</td>
<td>42.9</td>
<td>35.3</td>
<td>13.6</td>
</tr>
</tbody>
</table>

Correlations between the SIDES-SR scales were also examined as an index of internal consistency. The subscales are significantly correlated with each
other, and range from .32 to .60 (all coefficients are significant at $p < .01$) (the SIDES-SR scale inter-correlations are shown in Table 6). Together, the above data provide evidence for the internal consistency of the SIDES-SR.

Table 6

*Intercorrelations between SIDES-SR Current Scales*

<table>
<thead>
<tr>
<th></th>
<th>SIDES-SR I</th>
<th>SIDES-SR II</th>
<th>SIDES-SR III</th>
<th>SIDES-SR IV</th>
<th>SIDES-SR V</th>
<th>SIDES-SR VI</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDES-SR I</td>
<td>1.0</td>
<td>.52</td>
<td>.58</td>
<td>.57</td>
<td>.49</td>
<td>.60</td>
</tr>
<tr>
<td>SIDES-SR II</td>
<td>.52</td>
<td>1.0</td>
<td>.43</td>
<td>.32</td>
<td>.53</td>
<td>.39</td>
</tr>
<tr>
<td>SIDES-SR III</td>
<td>.58</td>
<td>.43</td>
<td>1.0</td>
<td>.50</td>
<td>.44</td>
<td>.59</td>
</tr>
<tr>
<td>SIDES-SR IV</td>
<td>.57</td>
<td>.32</td>
<td>.50</td>
<td>1.0</td>
<td>.48</td>
<td>.49</td>
</tr>
<tr>
<td>SIDES-SR V</td>
<td>.49</td>
<td>.53</td>
<td>.44</td>
<td>.48</td>
<td>1.0</td>
<td>.35</td>
</tr>
</tbody>
</table>

All correlations are significant at $p < .01$

SIDES-SR I - Affect Dysregulation  
SIDES-SR II - Attention/Consciousness  
SIDES-SR III - Altered Perceptions of Self  
SIDES-SR IV - Altered relationships  
SIDES-SR V - Somatization  
SIDES-SR VI - Meaning

*Validity Analyses*

To determine the convergent validity of the SIDES-SR, zero-order correlations between the total scale and subscale scores of the SIDES-SR and the other theoretically related measures (Cognitive Distortions Scales, Multiscale Dissociation Inventory, Inventory of Altered Self Capacities, and Somatoform Dissociation Questionnaire) were calculated. The full correlational data are
included in Tables 24 through 27 in Appendix F, and support the convergent validity of the SIDES-SR with the other measures.

The SIDES-SR Affect Dysregulation scale (Scale I) correlates with the IASC Affect Dysregulation scale \( (r = .61, p < .01) \) and the IASC Tension Reduction Scale \( (r = .60, p < .01) \) (see Table 24 in Appendix F). The SIDES-SR Alterations in Attention and Consciousness Scale (Scale II, which assesses for Dissociation) correlates with the Multiscale Dissociation Inventory Scales, with Pearson \( r \) coefficients ranging from .45 to .60 \( (p < .01 \) for all coefficients; see Table 25 in Appendix F). The SIDES-SR Scale II (dissociation) also correlates with the DAPS Trauma-specific Dissociation scale \( (r = .60, p < .01; \) see Table 27), and with the Somatoform Dissociation Questionnaire total score \( (r = .57, p < .01) \). The SIDES-SR Scale III (Alterations in Self-Perceptions) correlates, as expected, with the IASC Identity Scales \( (r = .37 \) and .49, \( p < .01 \) for both coefficients; see Table 24) and with the Cognitive Distortions Scales \( (r = .52 \) to .56, \( p < .01 \) for all five coefficients; see Table 26 in Appendix F). Scale IV of the SIDES-SR (Altered Relationships) correlates with the three IASC Altered Relationships Scales \( (r = .49 \) to .54, \( p < .01 \) for all coefficients; see Table 24). The Somatization scale of the SIDES-SR (Scale V) correlates with the Somatoform Dissociation Questionnaire \( (r = .48, p < .01) \). Finally, the Altered Systems of Meaning Scale of the SIDES-SR (Scale VI) (which measures despair and change in philosophy) correlates with the CDS Hopelessness Scale \( (r = .65, p < .01) \) and with the CDS Preoccupation with Danger Scale \( (r = .51, p < .01) \). These data provide
supporting evidence for the convergent validity of the SIDES-SR with the other measures chosen for this study, and support the validity of the C-PTSD construct.

Principal components analysis of total scale scores for all measures was conducted to explore potential underlying processes. Scales from the DAPS, IASC, MDI, CDS, SDQ-20, and Current SIDES-SR were entered into Principal Components Analysis, using Direct Oblimin rotation. As can be seen from the Scree plot of the data structure (Figure 1), a large main factor is evident, which accounts for 52.8% of the variance. The loadings for the dominant factor are shown in Table 7 and support the construct validity of C-PTSD as assessed by these measures.

Although some readers might argue that the Scree plot suggests two main factors, it has been suggested that strict unidimensionality is a conceptual ideal that may not be found in practice. As such, it would be reasonable to conceptualize the dimensionality issues as essential dimensionality. Essential dimensionality manifests as one dominant dimensional factor, with other minor factors of relatively equal magnitude trailing off (see Junker & Stout, 1994). With Principal Components Analysis, this is seen as one large factor that tends to have an eigenvalue of three to four times the magnitude of the next largest factor, and eigenvalues of the remaining factors having similar magnitude, which is clearly evident in the Scree plot in Figure 1. This suggests a clear case of unidimensionality – that is, one large latent variable accounts for the variation in the observed variables.
Figure 1

Scree Plot of the Factors of the Detailed Assessment of Posttraumatic Stress, Cognitive Distortions Scales, Multiscale Dissociation Inventory, Inventory of Altered Self Capacities, Somatoform Dissociation Questionnaire, and Self-Inventory for Disorders of Extreme Stress

Scree Plot
### Table 7

**Factor Loadings on the Detailed Assessment of Posttraumatic Stress, Cognitive Distortions Scales, Multiscale Dissociation Inventory, Inventory of Altered Self Capacities, Somatoform Dissociation Questionnaire, and Self-Inventory for Disorders of Extreme Stress (N = 207)**

<table>
<thead>
<tr>
<th>Scale</th>
<th>Loading</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDS Self blame</td>
<td>.84</td>
</tr>
<tr>
<td>CDS Preoccupation w Danger</td>
<td>.83</td>
</tr>
<tr>
<td>CDS Self-criticism</td>
<td>.81</td>
</tr>
<tr>
<td>CDS Helplessness</td>
<td>.80</td>
</tr>
<tr>
<td>DAPS Posttraumatic Symptoms Total</td>
<td>.79</td>
</tr>
<tr>
<td>IASC Affect Control</td>
<td>.79</td>
</tr>
<tr>
<td>IASC Identity Impairments</td>
<td>.78</td>
</tr>
<tr>
<td>MDI Derealization</td>
<td>.77</td>
</tr>
<tr>
<td>MDI Disengagement</td>
<td>.77</td>
</tr>
<tr>
<td>CDS Hopelessness</td>
<td>.76</td>
</tr>
<tr>
<td>MDI Depersonalization</td>
<td>.75</td>
</tr>
<tr>
<td>MDI Memory Disturbance</td>
<td>.74</td>
</tr>
<tr>
<td>IASC Interpersonal Relatedness</td>
<td>.73</td>
</tr>
<tr>
<td>MDI Emotional Constriction/Numbing</td>
<td>.71</td>
</tr>
<tr>
<td>SIDES-SR Affect</td>
<td>.69</td>
</tr>
<tr>
<td>DAPS Trauma—specific Dissociation</td>
<td>.69</td>
</tr>
<tr>
<td>SIDES-SR Attention</td>
<td>.69</td>
</tr>
<tr>
<td>Somatoform Dissociation</td>
<td>.67</td>
</tr>
<tr>
<td>SIDES-SR Self Perception</td>
<td>.63</td>
</tr>
<tr>
<td>SIDES-SR Relationships</td>
<td>.62</td>
</tr>
<tr>
<td>SIDES-SR Somatization</td>
<td>.60</td>
</tr>
<tr>
<td>MDI Multiplicity</td>
<td>.58</td>
</tr>
<tr>
<td>SIDES-SR Meaning</td>
<td>.58</td>
</tr>
</tbody>
</table>

*Note. CDS = Cognitive Distortions Scales; DAPS = Detailed Assessment of Posttraumatic Stress; IASC = Inventory of Altered Self Capacities; MDI = Multiscale Dissociation Inventory; SIDES-SR = Self Inventory for Disorders of Extreme Stress*

The theory behind the construct of C- PTSD holds that PTSD and Disorders of Extreme Stress (SIDES-SR scales) are highly related to each other.
The significant correlation between the DAPS PTSD scale and SIDES-SR total score support this premise underlying the C-PTSD construct \( (r = .59, \ p < .01) \) (as shown in Table 8).

Table 8

Zero-order Correlations between Scale Total Scores

<table>
<thead>
<tr>
<th></th>
<th>SIDES-SR</th>
<th>DAPS PTSD</th>
<th>IASC</th>
<th>MDI</th>
<th>CDS</th>
<th>SDQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDES-SR</td>
<td>1.0</td>
<td>.59</td>
<td>.63</td>
<td>.57</td>
<td>.72</td>
<td>.57</td>
</tr>
<tr>
<td>DAPS PTSD</td>
<td>1.0</td>
<td>.59</td>
<td>.70</td>
<td>.64</td>
<td>.49</td>
<td></td>
</tr>
<tr>
<td>IASC</td>
<td>1.0</td>
<td>.58</td>
<td>.81</td>
<td>.49</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MDI</td>
<td>1.0</td>
<td>.62</td>
<td>.60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDS</td>
<td>1.0</td>
<td>.45</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SDQ</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All correlations are significant at \( p < .01 \)

SIDES-SR = Self Inventory for Disorders of Extreme Stress
DAPS PTSD = Detailed Assessment of Posttraumatic Stress PTSD scale
IASC = Inventory of Altered Self Capacities
MDI = Multiscale Dissociation Inventory
CDS = Cognitive Distortions Scales
SDQ = Somatoform Dissociation Questionnaire

The theory behind the C-PTSD construct also holds that C-PTSD has its etiological basis in interpersonal traumas and childhood neglect. Table 9 shows the correlations between overt types of childhood maltreatment and neglect and the measures selected to assess C-PTSD in this study.
Table 9

**Zero-order Correlations between Childhood Adversity and Posttraumatic Sequelae**

*(N = 207)*

<table>
<thead>
<tr>
<th>Type of Childhood Maltreatment</th>
<th>DAPS PTSD</th>
<th>SDQ-20</th>
<th>CDS</th>
<th>MDI</th>
<th>IASC</th>
<th>SIDES -SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Felt Unloved</td>
<td>.25**</td>
<td>.27**</td>
<td>.25**</td>
<td>.24**</td>
<td>.23**</td>
<td>.24**</td>
</tr>
<tr>
<td>Psychological Abuse</td>
<td>.31**</td>
<td>.28**</td>
<td>.35**</td>
<td>.26**</td>
<td>.32**</td>
<td>.39**</td>
</tr>
<tr>
<td>Physical Abuse</td>
<td>.22**</td>
<td>.25**</td>
<td>.22**</td>
<td>.12</td>
<td>.18*</td>
<td>.39**</td>
</tr>
<tr>
<td>CSA – No penetration</td>
<td>.27**</td>
<td>.15*</td>
<td>.26**</td>
<td>.21**</td>
<td>.20**</td>
<td>.29**</td>
</tr>
<tr>
<td>Severity CSA – No penetration</td>
<td>.35**</td>
<td>.31**</td>
<td>.32**</td>
<td>.32**</td>
<td>.25**</td>
<td>.27**</td>
</tr>
<tr>
<td>CSA with Penetration</td>
<td>.31**</td>
<td>.22**</td>
<td>.24**</td>
<td>.30**</td>
<td>.20**</td>
<td>.36**</td>
</tr>
<tr>
<td>Severity of CSA with Penetration</td>
<td>.33**</td>
<td>.28**</td>
<td>.31**</td>
<td>.32**</td>
<td>.22**</td>
<td>.32**</td>
</tr>
<tr>
<td>Maltreatment Severity Index</td>
<td>.37**</td>
<td>.25**</td>
<td>.26**</td>
<td>.19**</td>
<td>.21**</td>
<td>.27**</td>
</tr>
</tbody>
</table>

*Note.* CSA = Childhood Sexual Abuse; DAPS = Detailed Assessment of Posttraumatic Stress; SDQ-20 = Somatoform Dissociation Questionnaire; CDS = Cognitive Distortions Scales; MDI = Multiscale Dissociation Inventory; IASC = Inventory of Altered Self Capacities; SIDES-SR = Self Inventory for Disorders of Extreme Stress.

* p < .05  **p < .01

**Group Demographics**

There were no significant differences between the internet and clinical samples on demographic or abuse history variables, and thus they were pooled for analysis. All but one of the participants from the internet indicated that they had received psychotherapy in the past and/or were currently in psychotherapy.
The internet/community group (Mean age = 41.2) was significantly older than the male inmate group \((t = 3.3_{171}, p = .001)\), male inmates (Mean age = 35.9) were older than female inmates (Mean age = 31.4) \((t = 2.5, 95, p = .02)\), and the internet/community group (mean age = 41.1) was older than female inmates \((t = 5.3, 142, p = .00)\).

Table 10

**Correctional versus Clinical/Internet samples on Demographics and Childhood Maltreatment Histories**

<table>
<thead>
<tr>
<th>Demographic and Childhood Maltreatment Variables</th>
<th>Male Inmates ((n = 63))</th>
<th>Female Inmates ((n = 34))</th>
<th>Internet/Comm Sample ((n = 110))</th>
<th>Total Sample ((n = 207))</th>
<th>(\chi^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal Race</td>
<td>19.4%</td>
<td>20.6%</td>
<td>0.9%</td>
<td>15%</td>
<td>30.73**</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parental Substance Abuse</td>
<td>73%</td>
<td>58.8%</td>
<td>32.7%</td>
<td>50%</td>
<td>27.49**</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessed Domestic Violence</td>
<td>65.1%</td>
<td>44.1%</td>
<td>45.5%</td>
<td>52%</td>
<td>6.99*</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt Unloved by Mother</td>
<td>9.5%</td>
<td>14.7%</td>
<td>38.5%</td>
<td>26%</td>
<td>20.1**</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Felt Unloved by Father</td>
<td>32.8%</td>
<td>21.2%</td>
<td>34.9%</td>
<td>32%</td>
<td>2.19 ns</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Psychological Abuse</td>
<td>69.8%</td>
<td>73.5%</td>
<td>90.7%</td>
<td>83%</td>
<td>13.2**</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Physical Abuse</td>
<td>61.8%</td>
<td>61.9%</td>
<td>66.4%</td>
<td>66%</td>
<td>0.45 ns</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood sexual abuse</td>
<td>58.7%</td>
<td>79.4%</td>
<td>90%</td>
<td>80%</td>
<td>23.4**</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loss of Caregiver</td>
<td>30.2%</td>
<td>20.6%</td>
<td>26.4%</td>
<td>27%</td>
<td>1.0 ns</td>
</tr>
<tr>
<td>(2\ text{ df})</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*\(p < .05\)   **\(p < .01\)
Childhood Adversity

Of the total sample, half reported their parents had drug or alcohol abuse problems when the individual was a child, and just over half reported having witnessed domestic violence during childhood (see Table 10). Male inmates were more likely to report parental substance abuse than the internet/community sample, and a higher percentage of male inmates witnessed family violence than did female inmates and the internet/community group. One-quarter to one-third of the sample reported that they had felt unloved by one or both parents during childhood. The male inmates were more likely to report that they felt loved by their mothers, whereas the internet/community group was less likely to report having felt loved by mother. Approximately one-third of the sample reported the loss of a significant caregiver during childhood (parent or parent surrogate) through death, divorce, juvenile detention, or foster placement.

A large percentage of the total sample reported overt forms of childhood abuse, with 66% reporting childhood physical abuse, 80% reporting childhood sexual abuse, and 83% reporting childhood psychological abuse. Fewer participants from the internet/community sample reported psychological abuse and sexual abuse than from male inmate sample. There were no group differences on percentages of individuals who reported childhood physical abuse or reported having felt unloved by father.

Self-Perceptions of Abuse and Objective Indices based on Self Report. The rates of various forms of abuse as measured by the Child Maltreatment Interview Schedule criteria were compared with the respondents' self-perceptions of
whether they had been abused. Sixty-five percent (132) of the respondents met objective criteria for childhood physical abuse. Of these, five (4%) did not consider themselves to have been physically abused (one female inmate, two male inmates, and two from the internet/clinic sample), whereas 25 (33%) of those who did not meet the CMIS criteria for CPA perceived themselves as having experienced CPA (4 female inmates, 5 male inmates, and 16 internet/clinic). The differences between objective criteria of physical abuse and self-perceptions of physical abuse were statistically significant ($\chi^2 = 92.74, 1, p < .001$). Group comparisons show that each group has significant discrepancies between self-perceptions of whether they had been physically abused and reported childhood physical abuse (for female inmates, $\chi^2 = 14.75, 1$, Fishers Exact test $p < .001$; for male inmates, $\chi^2 = 35.4, 1, p < .001$; and for the combined internet/clinic sample, $\chi^2 = 42.77, 1, p < .001$).

With regard to sexual abuse, of the 162 who met objective criteria for CSA, 26 (16%) did not consider themselves to have been sexually abused (5 female inmates, 14 male inmates, 7 combined), whereas three individuals (7%) who did not meet objective criteria considered themselves to have been sexually abused. Objective criteria and self perceptions were significantly different ($\chi^2 = 89.01, 1, p < .001$) (one female inmate, two from the combined sample). Comparisons within each group show that the differences for female inmates are significant ($\chi^2 = 7.52, 1$, Fishers Exact test $p < .02$); differences for male inmates are significant ($\chi^2 = 24.71, p. < .001$); and differences for the
combined internet/clinic sample are significant ($\chi^2 = .44.5, 1$, Fishers Exact test $p < .001$).

**Adulthood Victimization**

*Dichotomous Coding.* Ninety percent of the sample reported having experienced some form of victimization (psychological, physical, or sexual) after age 17. Approximately half reported psychological abuse or sexual abuse, and almost half reported physical assault (see Table 11). The three groups differed on rates of various types of victimization during adulthood. The female inmates reported more physical abuse than the internet/clinic sample; the male inmates reported significantly less psychological abuse than the other two samples; male inmates were less likely to report sexual assault than the other two groups and were more likely to deny any form of victimization than the female inmates and the internet/clinic group.

**Table 11**

*Percentages of Adult Victimization as a Function of Sample Source*

<table>
<thead>
<tr>
<th>Type of Adulthood Victimization</th>
<th>Male Inmates (n = 63)</th>
<th>Female Inmates (n = 34)</th>
<th>Internet/Comm Sample (n = 110)</th>
<th>Total Sample (n = 207)</th>
<th>$\chi^2$ (2 df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Psychological Abuse</td>
<td>31.7</td>
<td>58.8</td>
<td>53.6</td>
<td>49</td>
<td>9.66**</td>
</tr>
<tr>
<td>Adult Sexual Victimization</td>
<td>19.4</td>
<td>70.6</td>
<td>70.9</td>
<td>52</td>
<td>46.4**</td>
</tr>
<tr>
<td>Adult Physical Victimization</td>
<td>67.2</td>
<td>79.4</td>
<td>55.5</td>
<td>45</td>
<td>7.07*</td>
</tr>
<tr>
<td>Any Victimization</td>
<td>74.6</td>
<td>94.1</td>
<td>93.6</td>
<td>90</td>
<td>15.1**</td>
</tr>
</tbody>
</table>

*p < .05      ** p < .01
*Revictimization Rates.* Almost all (90.8%) of those in this study with any type of childhood maltreatment reported some form of victimization during adulthood. Revictimization rates for specific types of maltreatment are as follows: 53.9% of those with childhood psychological abuse histories report psychological abuse during adulthood. For CPA, the rate of physical revictimization is 72.2%, and for CSA the rate of sexual revictimization is 65.6%.

Almost half of the sample (48.3%) reported having been psychologically abused by a partner, with no significant differences between groups. Close to one-third of the sample (28.2%) reported physical assault by a partner, with female inmates reporting more physical abuse by a partner than the other two groups ($\chi^2 = 47.8, 2, p < .01$). About one-third of the sample (32.9%) reported having experienced non-penetrative sexual assault by a partner, with the combined internet/clinic sample reporting more unwanted sexual touching than the inmates ($\chi^2 = 38.7, 2, p < .01$). With regard to sexual assault that involved penetration, 22.1% of the full sample reported penetrative sexual assault by a partner, with the internet/clinic sample reporting more penetrative sexual assault by a partner than the inmates ($\chi^2 = 22.7, 2, p < .01$).

Regression Analyses

For all regression analyses, stepwise order of entry was used. With stepwise order of entry, only those variables that significantly contribute to the prediction equation were allowed to enter into the model at each step. With the inclusion of new variables in the model at each step, the effects of those
variables that previously entered the model were re-assessed. Probability levels for entry and removal of the variables at each step were set at the beginning of the analysis, such that the probability level had to have been at a certain level for the variables to enter the model. If the probability level of a variable that was already in the model increase above the set point for removal, that variable was removed from the prediction equation. This process occurred at each step of the procedure (i.e., each time a new variable was considered by the program for inclusion in the model).

I set the probability level at which variables were allowed to enter into the equation at .15, and set the probability level at which variables were removed from the equation at .10. This higher probability level was done to ensure that all potentially important variables are considered in the model, and that variables were not excluded on statistical criteria alone (Tabachnick & Fidell, 2001). A potential disadvantage of this selection of levels of entry and removal is that it can include variables as predictors that have negligible effect sizes, inflating error rates. However, the use of partiailling methods to control for the effects of demographic and childhood maltreatment factors has the effect of giving greater statistical weight to those variables that are entered first and partialled, and lower weight to those variables entered last (i.e., the partiailling can deflate observed effect sizes for the posttraumatic sequelae variables used in these analyses) (see Briere, 1992b for a discussion). A higher level of statistical probability is thus useful to ensure that important variables are not excluded on statistical criteria alone.
In addition to using the stepwise procedure for selection of predictors, I used hierarchical regression analysis for all regressions. With hierarchical analysis, the variables were entered into the model in sets or blocks as determined by the researcher. After the first block of variables enters, the second block is added. The effects of the first block of variables (the covariates) are forced to stay in the model. This effectively allows for the effects of the first block of variables to be statistically controlled (partialled), such that the effects of the second block of variables over and above the effects of the first block can be determined, and so forth with each additional block.

Since there were group differences on various demographic variables, age, sex, group status (male inmate, female inmate, internet/clinical) and race were entered into logistic regression analyses as covariates on the first block, with stepwise entry. For the group status variable, male inmates, female inmates, and the combined internet/clinical groups were dummy coded. This would, in effect, determine whether possible differences between the male inmates, female inmates, and combined clinical/internet sample were having an effect with regard to predictors of revictimization. That is, if there were differences between these groups with regard to predictors of revictimization, the group status variable would enter the regression equation as a predictor. Hierarchical analyses were conducted for all types of adult victimization (physical, sexual, and various types of abuse by intimate partners), such that in the first block, demographic covariates (age, race, sex, group status) were entered with stepwise entry; in the second block, childhood maltreatment types (parental
substance abuse, witnessing parental violence, psychological abuse, feeling unloved by mother, feeling unloved by father, physical abuse, sexual abuse, and loss of caregiver), and childhood maltreatment severity index were entered using stepwise entry; and in the third block, PTSD (yes or no), substance abuse, peritraumatic dissociation, trauma-specific dissociation, and total scores on the Multiscale Dissociation Inventory, Cognitive Distortions Scales, Inventory of Altered Self Capacities, Somatoform Dissociation Questionnaire-20, and Current Self-Inventory for Disorders of Extreme Stress scales were entered, using stepwise entry methods. I chose this hierarchical order of entry as it is assumed that childhood maltreatment precedes symptomatology, and I was interested in discerning the effects of posttraumatic symptomatology over and above the effects of demographic, group status, and childhood maltreatment variables. That is, with this order of entry, the effects of demographics are partialled out in the first block and the effects of childhood maltreatment are partialled out in the second block. This allows for the determination of the effects of those posttraumatic sequelae variables in the third block that predict revictimization, while controlling (partialling) for any effects of demographics, group status, and childhood maltreatment.

*Physical Victimization during Adulthood*

In the first block I entered demographic variables using stepwise order of entry, on the second block I entered the childhood maltreatment variables with stepwise order of entry, and on the third block I entered PTSD (yes or no), and total scale scores on the Multiscale Dissociation Inventory (MDI), Cognitive
Distortions Scales (CDS), Inventory of Altered Self Capacities (IASC), Somatoform Dissociation (SDQ-20) and the Self-Inventory for Disorders of Extreme Stress (SIDES-SR) Current scale. Results indicate that the main predictors of physical revictimization include parental drug and alcohol abuse, childhood psychological abuse, childhood physical abuse, and somatoform dissociation. Trauma-specific dissociation (derealization, depersonalization, detachment) decreases the risk of physical revictimization ($\chi^2 = 47.8, 4$, Nagelkerke $R^2 = .31, p < .001$; Hosmer and Lemeshow goodness of fit $\chi^2 = 7.7, 4, p = .46$). Results are shown in Table 12.

Table 12

*Stepwise Hierarchical Logistic Regression Model of Physical Revictimization*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>$B$</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental Drug &amp; Alcohol Abuse</td>
<td>.75</td>
<td>4.3</td>
<td>2.1</td>
</tr>
<tr>
<td>Childhood Psychological Abuse</td>
<td>1.59</td>
<td>10.1</td>
<td>4.8</td>
</tr>
<tr>
<td>Childhood Physical Abuse</td>
<td>1.03</td>
<td>6.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Trauma-specific Dissociation</td>
<td>-.15</td>
<td>10.8</td>
<td>0.86</td>
</tr>
<tr>
<td>Somatoform Dissociation</td>
<td>.07</td>
<td>8.0</td>
<td>1.07</td>
</tr>
</tbody>
</table>

*Sexual Victimization during Adulthood*

In the first regression analysis, I entered demographic variables and childhood maltreatment types on the first two blocks, and PTSD and SIDES-SR current scores on the final block, to assess the predictive validity of the C-PTSD construct in sexual revictimization. Results indicate that the main predictors of
sexual revictimization include age, female sex, having felt unloved by mother, a
history of CSA, and Complex PTSD (see Table 13). The model \( \chi^2 = 87.7, 6, \)
Nagelkerke \( R^2 = .48, p < .01. \)

**Table 13**

*Stepwise Hierarchical Logistic Regression Model of Sexual Revictimization, with C-PTSD as Predictor*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>( B )</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.031</td>
<td>2.7</td>
<td>1.03</td>
</tr>
<tr>
<td>Female Sex</td>
<td>1.63</td>
<td>16.6</td>
<td>5.11</td>
</tr>
<tr>
<td>Felt Unloved by Mother</td>
<td>1.54</td>
<td>1.9</td>
<td>1.17</td>
</tr>
<tr>
<td>CSA</td>
<td>1.52</td>
<td>7.1</td>
<td>4.59</td>
</tr>
<tr>
<td>DAPS PTSD (yes or no)</td>
<td>.91</td>
<td>5.1</td>
<td>2.5</td>
</tr>
<tr>
<td>SIDES-SR Total score</td>
<td>.03</td>
<td>4.5</td>
<td>1.04</td>
</tr>
</tbody>
</table>

*Note.* CSA = Childhood Sexual Abuse; DAPS = Detailed Assessment of Posttraumatic Stress (PTSD scale); SIDES-SR = Self Inventory for Disorders of Extreme Stress

The analysis was repeated to determine if the additional measures used in
this study would contribute to the predictive validity. As such, the additional
measures of dissociation, cognitive distortions, altered self capacities, and
somatoform dissociation were added to the final block. Age and female sex
entered on the first block, accounting for \( \sim 32\% \) of the variance (Nagelkerke
\( R^2 = .317 \)). Having felt unloved by mother (mean rating \(< 2\) ) and a history of CSA
entered the model on block 2, accounting for \( 42\% \) of the variance. On the third
block, PTSD and Somatoform Dissociation entered the model (see Table 14). The
model \( \chi^2 (6, N = 189) = 81.84, \) Nagelkerke \( R^2 = .48, p < .001. \) Hosmer and
Lemeshow goodness of fit \( \chi^2 (8, N = 189) = 3.09, p = .93, \) with \( 79\% \) of the
sample correctly classified. Thus, PTSD and somatoform dissociation appear to
be those components of C-PTSD that have the strongest relation to sexual revictimization.

Table 14

**Stepwise Hierarchical Logistic Regression Model of Sexual Revictimization**

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.028</td>
<td>2.02</td>
<td>1.02</td>
</tr>
<tr>
<td>Female Sex</td>
<td>1.75</td>
<td>18.7</td>
<td>5.79</td>
</tr>
<tr>
<td>CSA</td>
<td>1.7</td>
<td>7.76</td>
<td>5.57</td>
</tr>
<tr>
<td>Unloved by Mother</td>
<td>.512</td>
<td>1.28</td>
<td>1.66</td>
</tr>
<tr>
<td>DAPS PTSD (yes or no)</td>
<td>.882</td>
<td>4.73</td>
<td>2.41</td>
</tr>
<tr>
<td>SDQ-20</td>
<td>.055</td>
<td>4.28</td>
<td>1.05</td>
</tr>
</tbody>
</table>

*Note.* CSA = Childhood Sexual Abuse; DAPS = Detailed Assessment of Posttraumatic Stress (PTSD scale); SDQ-20 = Somatoform Dissociation Questionnaire

**Intimate Relationship Victimization During Adulthood**

I explored various types of victimization within intimate relationships, using the same regression analyses methods as for previous models. I looked at the following types of revictimization within partnerships, using 3 separate regression analyses: physical abuse by a partner, sexual abuse by a partner, and combined psychological, physical, and sexual abuse by a partner.

**Physical Victimization by a Partner.** The main predictors of physical revictimization by a partner include being female and a history of childhood psychological abuse, PTSD, and IASC total scores (alterations in self capacities). Trauma-specific dissociation and victim-types of cognitive distortions decreased the odds of physical revictimization by a partner (see Table 15). The model $\chi^2$
(6, \(N=184\)) = 67.4, Nagelkerke \(R^2 = .45, p < .001\). Hosmer and Lemeshow goodness of fit \(\chi^2 (8, \ N = 191) = 7.16, p = .52\).

Table 15

*Stepwise Hierarchical Logistic Regression Model of Physical Victimization by a Partner*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>(B)</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sex</td>
<td>3.6</td>
<td>19.8</td>
<td>38.9</td>
</tr>
<tr>
<td>Child Psych. Abuse</td>
<td>3.1</td>
<td>7.1</td>
<td>21.2</td>
</tr>
<tr>
<td>T-DIS</td>
<td>-.18</td>
<td>9.3</td>
<td>.83</td>
</tr>
<tr>
<td>DAPS PTSD</td>
<td>1.03</td>
<td>3.3</td>
<td>2.8</td>
</tr>
<tr>
<td>CDS</td>
<td>-.02</td>
<td>4.0</td>
<td>.98</td>
</tr>
<tr>
<td>IASC Total</td>
<td>.02</td>
<td>9.2</td>
<td>1.02</td>
</tr>
</tbody>
</table>

*Note.* TDIS = Trauma-specific Dissociation; DAPS = Detailed Assessment of Posttraumatic Stress; CDS = Cognitive Distortions Scales; IASC = Inventory of Altered Self Capacities

*Sexual Victimization by Partner.* For sexual victimization by a partner, results show that the main predictors of sexual revictimization by a partner include females with childhood physical abuse histories who also felt unloved by their mothers, and who have higher somatoform dissociation scores (see Table 16). The model \(\chi^2 (4, \ N=184) = 53.2, Nagelkerke R^2 = .37, p < .001\).
Table 16

*Stepwise Hierarchical Logistic Regression Model of Sexual Victimization by a Partner*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sex</td>
<td>2.7</td>
<td>13.5</td>
<td>16.2</td>
</tr>
<tr>
<td>Felt unloved by Mother</td>
<td>.82</td>
<td>4.01</td>
<td>2.2</td>
</tr>
<tr>
<td>Childhood Physical Abuse</td>
<td>.46</td>
<td>1.03</td>
<td>1.5</td>
</tr>
<tr>
<td>Somatoform Dissociation</td>
<td>.04</td>
<td>4.8</td>
<td>1.04</td>
</tr>
</tbody>
</table>

*Combined Sexual, Physical, and Psychological Abuse by a Partner.* Female sex, witnessing parental violence, having felt unloved by mother, childhood physical abuse, and IASC total scores predicted the most severe form of revictimization by a partner (combined Psychological, Physical, and Sexual abuse). The model \( \chi^2 (5, N=184) = 35.5 \), Nagelkerke \( R^2 = .34 \), \( p < .001 \), Hosmer and Lemeshow \( \chi^2 (8, N=184) = 5.92 \), \( p = .66 \) (see Table 17).

Table 17

*Stepwise Hierarchical Logistic Regression Model of Psychological, Physical and Sexual Victimization by a Partner*

<table>
<thead>
<tr>
<th>Predictor</th>
<th>B</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female Sex</td>
<td>2.5</td>
<td>5.8</td>
<td>13.3</td>
</tr>
<tr>
<td>Witnessed Domestic Violence</td>
<td>1.04</td>
<td>3.6</td>
<td>2.8</td>
</tr>
<tr>
<td>Felt Unloved by Mother</td>
<td>.77</td>
<td>2.1</td>
<td>2.1</td>
</tr>
<tr>
<td>Childhood Physical Abuse</td>
<td>1.37</td>
<td>2.9</td>
<td>3.9</td>
</tr>
<tr>
<td>IASC Total score</td>
<td>.01</td>
<td>5.8</td>
<td>1.01</td>
</tr>
</tbody>
</table>

*Note.* IASC = Inventory of Altered Self Capacities
Perpetration

Male inmates committed significantly more physical violence than female inmates as measured by self-report ($\chi^2 = 14.91, 2$, Fisher's Exact Test $p < .001$) and official records ($\chi^2 = 19.31, 2, p < .001$) (see Table 18). Inmates committed significantly more physical violence than the combined internet/clinic sample as measured by self-report (for male inmates vs. non-inmates, $\chi^2 = 40.0, 2, p < .001$, and for female inmates v. non-inmates, $\chi^2 = 5.38, 2, p < .05$).

Table 18

Rates of Physical and Sexual Perpetration per Group

<table>
<thead>
<tr>
<th>Type of Perpetration</th>
<th>Female Inmates</th>
<th>Male Inmates</th>
<th>Internet &amp; clinical Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-reported Physical perpetration</td>
<td>67.6%</td>
<td>98.3%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Official Records of Physical Perpetration</td>
<td>32.4%</td>
<td>77.8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Physical Perpetration per self report or official records</td>
<td>73.5%</td>
<td>98.3%</td>
<td>44.8%</td>
</tr>
<tr>
<td>Self reported sexual perpetration</td>
<td>5.9%</td>
<td>27.1%</td>
<td>11.9%</td>
</tr>
<tr>
<td>Official records of sexual perpetration</td>
<td>5.9%</td>
<td>19%</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexual perpetration per self report or official records</td>
<td>5.9%</td>
<td>27.1%</td>
<td>11.9%</td>
</tr>
</tbody>
</table>

Female inmates committed significantly less sexual violence than male inmates, per self report ($\chi^2 = 7.32, 2$, Fisher's exact test, $p < .01$) and less than the combined internet sample, per self report ($\chi^2 = 4.46, 2$, Fisher's exact test, $p < .05$). There were no differences between male inmates and the combined internet sample on self-reported sexual perpetration ($\chi^2 = 1.52, 2, p = .22$).
When using official data from legal files, there was no difference between male inmates and female inmates on charges and/or convictions for sexual perpetration.

Table 19 depicts comparisons between the groups in terms of revictimization rates and perpetration rates. Results show that the inmate groups reported combined adult victimization and perpetration (i.e., they were both revictimized and perpetrated against others) significantly more often than the internet/clinic group. The internet/clinic group was more likely than the inmate groups to report revictimization only (no perpetration), and the male inmates were more likely than the other two groups to report that they perpetrated and were not victimized.

Table 19

*Revictimization and Any Perpetration based on Group Status*

<table>
<thead>
<tr>
<th>Revictimization and/or Perpetration</th>
<th>Female Inmates</th>
<th>Male Inmates</th>
<th>Internet</th>
<th>Chi-Square (2 df)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neither Revictimized nor perpetrated</td>
<td>2.9%</td>
<td>6.3%</td>
<td>10.9%</td>
<td>2.61 ns</td>
</tr>
<tr>
<td>Combined Revictimization and Perpetration</td>
<td>67.6%</td>
<td>67.7%</td>
<td>42.7%</td>
<td>12.89*</td>
</tr>
<tr>
<td>Revictimized Only</td>
<td>23.5%</td>
<td>1.6%</td>
<td>40.9%</td>
<td>32.26*</td>
</tr>
<tr>
<td>Perpetrated Only</td>
<td>5.9%</td>
<td>24.2%</td>
<td>5.5%</td>
<td>15.18*</td>
</tr>
</tbody>
</table>

*p < .01

Logistic Regression Analyses were calculated for those who did and did not perpetrate physical violence (per self-report or official records) and for those
who did and did not perpetrate sexual violence (per official records or self-report). The predictors that were entered into hierarchical stepwise logistic regression analyses include group, race, sex, age, substance abuse, PTSD, symptom scales (total scores on peritraumatic dissociation, trauma-specific dissociation, CDS, MDI, IASC, SIDES-SR, SDQ-20), and childhood maltreatment variables.

*Physical Perpetration.* For physical violence, results show that odds of perpetration were increased for male inmates with substance abuse problems, and decreased for the combined internet/clinic sample and a history of childhood sexual abuse. These results suggest that male inmates with substance abuse problems are more likely to perpetrate physical violence; however, with non-inmates with histories of CSA, odds are decreased. The model $\chi^2$ (4, $N = 176$) = 64.9, Nagelkerke $R^2 = .43$, $p < .001$ (see Table 20).

### Table 20

**Hierarchical, Stepwise Logistic Regression Model of Perpetration of Physical Violence**

<table>
<thead>
<tr>
<th>Predictors</th>
<th>$B$</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Inmates</td>
<td>2.6</td>
<td>4.9</td>
<td>13.9</td>
</tr>
<tr>
<td>Internet/Clinic Group</td>
<td>-1.1</td>
<td>2.4</td>
<td>.35</td>
</tr>
<tr>
<td>CSA</td>
<td>-1.2</td>
<td>2.8</td>
<td>.31</td>
</tr>
<tr>
<td>Substance abuse</td>
<td>.06</td>
<td>2.9</td>
<td>1.1</td>
</tr>
</tbody>
</table>

*Note.* CSA = Childhood Sexual Abuse

*Sexual Perpetration.* For regression analysis with sexual perpetration (using same method as above), results show that male inmates with higher IASC
scores are at increased risk of perpetrating sexual violence; however, victim-based cognitive distortions decrease the odds of sexual perpetration. The model $\chi^2 (3, N = 180) = 26.4$, Nagelkerke $R^2 = .23$, $p = .000$ (Table 21).

Table 21

*Stepwise Logistic Regression Model of Perpetration of Sexual Violence*

<table>
<thead>
<tr>
<th>Predictors</th>
<th>$B$</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Inmates</td>
<td>1.7</td>
<td>9.99</td>
<td>1.1</td>
</tr>
<tr>
<td>CDS Total</td>
<td>-.02</td>
<td>3.6</td>
<td>.98</td>
</tr>
<tr>
<td>IASC Total</td>
<td>.02</td>
<td>10.2</td>
<td>1.0</td>
</tr>
</tbody>
</table>

*Note. CDS = Cognitive Distortions Scales; IASC = Inventory of Altered Self Capacities*

In order to determine which aspects of cognitive distortions and impaired self capacities increase risk of sexual perpetration, the above analysis was repeated, except that IASC factors (affect regulation problems, interpersonal relatedness problems, and identity problems) were entered into the analysis in place of IASC total scores, and the scale scores from the Cognitive Distortions Scale were entered in place of CDS total scores. Results show that male inmates with affect dysregulation are at higher risk of perpetration of sexual violence and that hopelessness appears to decrease risk of sexual perpetration (see Table 22). The model $\chi^2 (4, N = 175) = 28.9$, Nagelkerke $R^2 = .25$, $p = .000$. 
Table 22

*Stepwise Logistic Regression Model of Peretration of Sexual Violence*

<table>
<thead>
<tr>
<th>Predictors</th>
<th>B</th>
<th>Wald Test (z-ratio)</th>
<th>Odds Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>.07</td>
<td>9.3</td>
<td>1.1</td>
</tr>
<tr>
<td>Male Inmates</td>
<td>1.9</td>
<td>12.7</td>
<td>6.9</td>
</tr>
<tr>
<td>IASC Affect Dysregulation</td>
<td>.07</td>
<td>13.6</td>
<td>1.1</td>
</tr>
<tr>
<td>CDS Hopelessness</td>
<td>-.06</td>
<td>4.3</td>
<td>.94</td>
</tr>
</tbody>
</table>

*Note.* CDS = Cognitive Distortions Scales; IASC = Inventory of Altered Self Capacities
Chapter 5. Discussion

The purpose of this study was to explore the potential predictive role of affect regulation problems, interpersonal relatedness difficulties, and PTSD in revictimization and in perpetration with individuals with childhood maltreatment histories. A sample of 207 men and women who were recruited from prisons, a community clinic, and the internet completed a battery of self-report questionnaires that inquired into various forms of childhood abuse, symptoms of posttraumatic stress disorder and related sequelae, and self-reported revictimization and perpetration during adulthood. Inmates' files were also coded for charges for violent and sexually violent offenses.

The findings from this study provide some new information on the relationship between childhood maltreatment and revictimization and the perpetration of violence for a general clinical/community sample and inmate samples. Although there were some differences between the inmate groups and between the inmate and non-inmate groups on some demographic variables (age, race), types of childhood maltreatment histories, adult victimization experiences, and perpetration history, group status *per se* did not enter into any of the revictimization regression models.

The discrepancies between objective criteria for childhood physical and sexual abuse and the respondents' self-perceptions of whether they had been abused are interesting. The data indicate that, where discrepancies exist, the main tendency was for individuals who did not meet criteria for CPA to perceive themselves as having been physically abused during childhood (33%), and for
individuals who met criteria for CSA to deny having been sexually abused during childhood (16%). Although it is possible that these findings are due to cultural factors (e.g., male inmates may have norms in which they deny vulnerabilities, such as sexual abuse), my findings are consistent with earlier studies that found similar discrepancies with non-inmate samples (e.g., Martin, Anderson, Romano, Mullen, & O'Shea, 1993). It is possible that the manner in which CPA and CSA were defined in the current study may have affected the reports. The criteria for CPA required that tissue damage be present; however, it is conceivable that individuals who received corporal punishment on a regular basis but did not experience tissue damage would nonetheless perceive themselves to have been physically abused. The definition of CSA was liberal in so far as it had a high upper cutoff (age 17); however, it excluded non-contact forms of sexual abuse. It is conceivable that participants who experienced non-contact forms of sexual abuse (e.g., exposure of genitals) would perceive themselves to have been sexually abused, even though they did not meet the study criteria for sexual abuse.

In terms of denial of CSA, similar findings were reported in one study wherein some women who had been sexually assaulted as measured by legal statute did not consider the episode to have been a sexual assault (Koss, Dinero, Siebel & Cox, 1988). This may reflect denial, minimization, or normalization (i.e., acceptance of “rape myths”) by some of the victims. Since some of the inmates in the current study were convicted sex offenders and since convicted offenders tend to rationalize their offending behavior, they may rationalize adult-child
sexual relationships as "normal," thereby denying not only that they are perpetrators, but that they were perpetrated against (this has been my experience clinically in working with convicted pedophiles). Such denial could also hold for female inmates and non-inmates. The finding that male inmates have the highest rates of denial of CSA even though they meet objectively coded criteria for CSA, is consistent with the finding that they rate themselves as not holding negative feelings about themselves. This may fit with a need for denying particular forms of vulnerability, either to maintain a façade of a "good" self-image, or to protect themselves from harm within dangerous prison environments. That is, they may be at increased risk of victimization within a prison environment should they reveal any vulnerabilities that would result in a presentation of "weakness," whether in their own perceptions or in the perceptions of others.

These findings on the denial of having been sexually assaulted or abused have implications for the meta-analyses conducted by Rind and colleagues, who reported that CSA is not associated with pervasive or severe harm in apparently non-clinical samples (a national probability sample and a college sample) (see Rind & Tromovitch, 1997; Rind, Tromovitch, & Bauserman, 1998). Given this pattern of results (consisting of denial of CSA in spite of meeting objectively coded criteria/definitions of CSA) is not specific to my sample (see Koss & Dinero, 1988; Martin et al., 1993), it stands to reason that similar denial may well have been occurring with some of the participants in the research by Rind and colleagues. In addition, if individuals are prone to deny that they were
victimized, they may also be more likely to deny or minimize any symptomatology. Moreover, meta-analyses do not take into consideration issues such as divergent definitions and severity of CSA in different studies, which will impact reported rates and outcome (e.g., harmfulness). It would be advantageous to measure individuals for "desirable responding" or "minimization" in future studies, and control this statistically.

Revictimization experiences were high in the present sample, with approximately ninety percent of participants reporting some form of adult victimization. The highest rates were for physical revictimization (possibly due to the increased physical violence within prison settings), followed by sexual revictimization, and psychological revictimization. With regard to revictimization by an intimate partner, almost half the sample reported having experienced psychological abuse by a partner, about one-third reported non-penetrative sexual abuse by a partner, close to one-third reported physical abuse by a partner, and approximately one-fifth reported penetrative sexual abuse by a partner. These data are consistent with results from previous studies that have shown that individuals with childhood maltreatment histories are at increased risk of various forms of revictimization by individuals unknown to them, and also by intimate partners.

Gender was found to consistently predict revictimization (with females at higher risk). One exception was with any physical victimization during adulthood, where gender did not enter the model. In Table 23, I provide a visual summary of the predictors of various forms of revictimization. Before proceeding with this
In the discussion, I would like to point out that the term “predictor” is intended solely in the statistical sense of that term (i.e., as a correlation), and is not intended to imply that the predictor variables cause the dependent variables.

Table 23

**Visual Summary of Predictors of Various Forms of Adult Victimization**

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Any APA</th>
<th>Any ASA</th>
<th>Part. APA</th>
<th>Part. ASA</th>
<th>Part. APs, APA &amp; ASA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Parental Drug /Alcohol Abuse</td>
<td>+</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witnessing Domestic Violence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>Unloved by Mother</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>CPsA</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CPA</td>
<td>+</td>
<td></td>
<td></td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>CSA</td>
<td></td>
<td></td>
<td></td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>PTSD</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
<td></td>
</tr>
<tr>
<td>T-DIS</td>
<td>-</td>
<td></td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CDS</td>
<td></td>
<td></td>
<td></td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>IASC</td>
<td></td>
<td></td>
<td>+</td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>SDQ-20</td>
<td>+</td>
<td>+</td>
<td></td>
<td>+</td>
<td></td>
</tr>
</tbody>
</table>
The most robust historical predictors across various types of revictimization for this sample include female gender, having felt unloved by mother during childhood and adolescence (implying attachment-related difficulties), and various types of childhood maltreatment/adversity. These findings are consistent with several other studies that have reported childhood adversity of individuals who are victimized during adulthood. Overt forms of childhood maltreatment appear to not function in isolation to increase risk of later victimization, but family environment and attachment relationships may also contribute to risk for later harm.

The results of this study provide partial support for the hypothesis that affect dysregulation, problems with interpersonal relatedness, and PTSD increase risk of sexual victimization of adults who were abused as children. PTSD played a role in any sexual revictimization (i.e., sexual revictimization by those known or unknown to the individual), and in physical victimization by an intimate partner. Impaired self capacities (which involve affect dysregulation and problems with interpersonal relatedness) predicted physical victimization by a partner and predicted combined physical, psychological, and sexual victimization by a
partner. Thus, it would appear that impaired self capacities play a role in abuse by intimate partners, but may not be a key factor in victimization by strangers.

The negative relationship between victim-type cognitive distortions and two types of intimate partner revictimization involving physical abuse is counterintuitive. One would expect victims of physical violence by partners to have more victim-type cognitions, not less. It is possible that denial that one is a victim plays a role as a defense against the full knowledge of partner abuse for these individuals. That is, denial may constitute a particular form of dissociation of knowledge or awareness, such that the individual avoids emotional distress by failing to acknowledge that one is being victimized.

The subsidiary hypothesis that C-PTSD will predict sexual revictimization was supported by these findings; however, the findings need to be qualified. PTSD and SIDES-SR total scores (i.e., C-PTSD) predict sexual revictimization when controlling for demographic variables and childhood maltreatment. However, when looking more closely at the components of C-PTSD (i.e., by looking at the various measures used to assess C-PTSD in this study), it would appear that PTSD and somatoform dissociation are the components of C-PTSD that function to particularly place individuals at risk of any sexual and/or physical revictimization (i.e., revictimization by strangers or partners).

The subsidiary hypothesis that C-PTSD would predict other forms of revictimization was not supported by the results. Controlling for demographics and childhood maltreatment, C-PTSD failed to predict other types of revictimization. Consistent with other studies cited earlier, substance abuse did
not predict sexual revictimization, physical revictimization, or victimization within intimate partnerships, which calls into question the substance abuse risk factor in Cloitre’s (1998) model.

Of interest, trauma-specific dissociation decreased risk of physical revictimization. It is conceivable that those who avoid interpersonal reminders of their traumatic experiences, such as intimate relationships, would be at decreased risk of revictimization, in that they may have less exposure to potential perpetrators. Peritraumatic dissociation and trait dissociation failed to predict any type of revictimization, which is consistent with several studies reported in the literature. In combination, these findings seem to call into question the oft-cited theory that dissociation increases risk of revictimization due to the individual’s inattentiveness to his or her surroundings. It is also in opposition to Cloitre’s (1998) model. On the other hand, to the extent that somatoform dissociation and other types of dissociation have shared variance, the predictive strength of somatoform dissociation in revictimization may also function to decrease the statistical effects of the other types of dissociation that were assessed in this study. The predictive validity of any one variable in a regression model depends on what else is in the model, and thus the results would likely differ if different \textit{a priori} predictive variables were chosen and studied.

In terms of perpetration of physical or sexual violence, male inmates perpetrated significantly more physical violence than female inmates, per self report and per official records. Inmates (male and female) perpetrated more
physical violence than the non-inmate sample, although rates of interpersonal
perpetration were still high for the non-inmate sample (48.2 percent). Male
inmates perpetrated significantly more sexual violence than female inmates, and
the clinical/internet sample perpetrated significantly more self-reported sexual
violence than did the female inmates. The rates of physical and sexual
perpetration in the non-inmate sample suggest that rates of perpetration by
individuals with childhood maltreatment histories are higher than previously
thought. The majority of the internet/clinic sample was female, which suggests
that females may be at higher risk of perpetration than previously thought. It is
possible, however, that females engage in aggression as attempts at self-defense
(this basis for the perpetration was not examined in the current study). This is an
important area for future research.

Contrary to the original hypothesis, only static predictors and substance
abuse increased risk of physical perpetration with this sample, with male inmates
with drug or alcohol abuse problems committing more physical violence. It
would appear that substance abuse, possibly used as a posttraumatic-coping
mechanism (i.e., as a strategy to regulate negative affect), is one effect of
childhood adversity that disinhibits aggressive controls, leading to more violent
behavior. Childhood sexual abuse and non-inmate status decreased the odds of
perpetration of physical violence. Although violent offenders, sex offenders, and
individuals with childhood maltreatment histories tend to score high in
dissociation, none of the different types of dissociation measured in this study
predicted violence or sexual violence for the full sample.
Male inmates were at increased risk of perpetrating sexual violence. Altered self-capacities also increased risk of sexual perpetration, and victim-based cognitive distortions decreased the odds. Upon further exploration to discern which component(s) of altered self-capacities are associated with sexual perpetration, and which component(s) of cognitive distortions decrease risk of sexual perpetration, affect dysregulation was found to be the strongest IASC predictor. This finding is consistent with the proposal by Ward et al. (1998) that under-regulation or mis-regulation of affect states is involved with sexual perpetration.

Limitations

The above findings need to be understood with the limitations of this research in mind. First, the study used retrospective, self-report methodology. Individuals were asked to report on posttraumatic symptomatology that was assumed to be based in the original childhood trauma; however, it is conceivable that the posttraumatic symptomatology is based in both the childhood trauma and adult traumas (including revictimization), or that it is based solely in adult trauma. The non-prospective design of the study precludes clear conclusions regarding directionality. In addition, the vagaries of memory over time may impact the reliability of retrospective ratings, particularly with regard to the timeline (e.g., onset) of symptoms.

Another limitation is the heterogeneity of the samples. There were some differences between the groups on some of the demographic, childhood maltreatment, and adult victimization variables. Group status did not enter the
majority of the revictimization regression models (with one exception) and thus
did not appear to play a statistical role in revictimization; however, it cannot be
concluded that group status did not play any role. The use of dummy coding and
controlling for selected demographic variables does not create equality between
groups, and there may be unmeasured variables that both differ between the
groups and that may have contributed to the observed findings. The pooling of
groups in the current study has the disadvantage of obscuring potentially
important differences that may arise if un-pooled groups were examined
separately. Thus, generalizability is limited. Separate regression analyses for each
group could help to clarify; however this would require a larger sample size for
there to be sufficient power. Moreover, the non-representative sampling method
used in this study limits the generalizability of the findings. These results may be
particular to these samples, and may not generalize to other survivors of
childhood maltreatment.

Another limitation involves the possibility of participants giving socially
desirable responses and/or engaging in denial or minimization of their
experiences. Additionally, the upper age cutoff of 17 to define childhood abuse
could be viewed as disadvantageous by some, in that adolescence differs from
childhood as a specific developmental stage, and the predictors of revictimization
and perpetration for those abused at younger ages may differ from those abused
during adolescence. It is possible, for example, that abuse at younger ages may
impact affect regulation abilities more than abuse during adolescence, and that
abuse during adolescence may have a stronger impact on sexual identity than
abuse during younger ages. Similarly, abuse during adolescence could be more harmful in that older children may experience more feelings of guilt insofar as they are more aware of social norms than are younger children.

Finally, the methodology allows for the initial identification of risk factors for revictimization; however, it does not shed much light on the intrapsychic processes that are involved in revictimization experiences. For example, my results suggest that PTSD and somatoform dissociation could increase the risk of any sexual revictimization. However, in the absence of a prospective, longitudinal study, it is not clear whether PTSD and somatoform dissociation could be involved in increasing vulnerability to revictimization, or whether revictimization may increase symptoms of PTSD and somatoform dissociation, whether both of these possibilities hold. If PTSD and somatoform dissociation increase the risk of revictimization, my results per se do not provide information on why that might be. If we return to the two narrative quotes at the beginning of Chapter 1 from two research respondents, their experiences would suggest that they were unable to think clearly or take appropriate action at the time of their revictimization. Nijenhuis, Vanderlinden and Spinhoven (1998) postulate that negative somatoform dissociative symptoms increase risk of revictimization through their association with conditioned defensive reactions, such as freezing. The narrative quotes from the two research participants also suggest that the revictimization led to flashbacks of earlier sexual abuse (PTSD symptoms). Structural equation analyses could be used to test this hypothesis; however, the directionality issue would still not be wholly resolved in the absence of a
prospective study. Another possibility is that the individuals developed delayed onset PTSD from the original sexual abuse, which had been triggered by the adult sexual revictimization.

Proposed Routes to Revictimization and Further Study

I propose that there may be at least three different routes to revictimization, which are suggested for future study. Those who are more severely traumatized may be at risk of revictimization through all three of these routes. Untreated symptoms of PTSD increase survivors’ vulnerability to experience conditioned negative emotions to reminders of their trauma. The triggering of conditioned emotional responses may activate state-dependent memory schemas (implicit or explicit) of previous abuse. These schemas can include thoughts, feelings, perceptions, sensations, and behaviors. If the original traumatic event resulted in a “freeze” or “submit” response, the probability of this behavior recurring when state-dependent abuse memories are elicited would increase, thereby increasing risk of revictimization (sexual or physical). My findings that PTSD and somatoform dissociation are the strongest predictors of any revictimization (sexual or physical), controlling for demographic and childhood maltreatment variables, supports this view. Attachment-related disturbances and affective dysregulation are not necessarily involved in this pathway.

A second proposed route (to sexual revictimization in particular) involves Finkelhor’s (1987) traumagenic dynamics, in combination with state dependent memory activation. In this proposed scenario, learned sexualized behaviors,
coupled with difficulties with trust, lead some survivors to engage in significant testing of the trustworthiness of others. They may engage in sexualized behaviors in an attempt to discern who and who is not trustworthy, which increases their risk of revictimization. The failure to develop sexual affect regulation skills may also contribute to this vulnerability. Should the recipient of this testing respond in kind, the individual may experience state-dependent powerlessness and freezing, and his or her experience is one of revictimization, which reinforces his or her sense of sexual stigmatization and their difficulties with trusting others. The failure to develop sexual affect regulation skills coupled with state-dependent activation may also contribute to revictimization in that, to the extent that the individual is unable to control sexual arousal in response to the activities of the person being "tested," the individual may feel helpless to stop the activity, and thus experiences revictimization. This route (in modified form) may also account for some forms of physical revictimization – these individuals may fear aggression of others and may "test" the trustworthiness of others by acting provocatively (not necessarily in a sexual manner). Thus, what appear to be sexually or aggressively provocative behaviors may be based in underlying fear and difficulties with learning appropriate ways of determining who is trustworthy.

When attachment disruptions result in significant impairments in affect regulation capacities, the individuals' implicit relational schemata may be constantly triggered within their relationships, they become reactivated emotionally and are unable to modulate the arousal with internal resources. This
constitutes the third proposed route to revictimization. This may lead to behavioral re-enactments, including aggression and dependency within relationships. The effects of betrayal trauma (see Freyd, 1997) – the knowing that one is being abused and yet "not knowing" or appreciating this fully, when carried into adult relationships, may function to keep individuals tied to an abusive partner. They may utilize thought suppression or other defense mechanisms, such as rationalization, denial, or splitting to keep distress from the knowledge of abuse from overwhelming their abilities to function. With regard to sexual revictimization by partners, traumagenic dynamics may also be involved, and the lack of opportunity of the individual to learn effective sexual modulation skills during normative development may also increase risk of sexual revictimization within longterm intimate relationships. An inability to effectively modulate sexual arousal may also increase risk of sexual perpetration by those who do not have sufficient internal controls.

Additional ideas for future research include conducting prospective, longitudinal studies, where individuals are assessed at baseline for childhood maltreatment and posttraumatic symptoms, followed over a certain period of time (e.g., one year), and then reassessed for posttraumatic symptoms and any victimization experiences during the pre-post interval. Such data would be very useful in teasing apart the directional roles of PTSD and other sequelae (e.g., somatoform dissociation, altered self-capacities) in revictimization.

Once robust predictors of revictimization are identified, the development and validation of actuarial risk assessment instruments (for the assessment of
risk of revictimization) could occur. Such instruments could provide useful information on which clients are at the highest risk of being revictimized, and the specific risk factors endorsed by a given client could become a key focus of treatment.

Implications

The construct of Complex PTSD or DESNOS is based in a clinically and empirically-derived theory, which provides an advantage over many of the syndromes listed in the current DSM that have no specified etiological basis. The symptom/behavior picture of Complex PTSD is thought to arise from chronic interpersonal traumatic events, which occur within an unhealthy context and impact the individual on many levels – physiological, structural, emotional, psychological, and social.

The results from this study suggest that the DESNOS construct as measured by the SIDES-SR has acceptable internal consistency, and the correlations with the other measures in the study provide evidence for convergent validity. The correlations between childhood adversity and the various scales also provide evidence of construct validity. The internal consistency and validity findings on the measures in this study provide some support for the homogeneity of the C-PTSD or DESNOS construct, as do the findings that childhood maltreatment and the measures in this study are significantly correlated with each other. However, it is not clear whether the construct stands up to criticisms of our classification system of mental disorder (DSM).
Complex PTSD and Classification

Our current taxonomic system (DSM) is thought to constitute a flawed classification system upon which to conduct research programs given the focus on symptoms and behavioral complexes and the lack of theoretical covering laws to draw them together (Follette & Houts, 1996). What is left is an expansive set of categories that are internally heterogenous and not well bounded from each other. The result is the absence of a parsimonious empirically-based system to form the basis of research.

The results from the DSM-IV field trial on the DESNOS or C-PTSD construct led the field trial researchers to the proposal that several of the diagnostic categories in the DSM may actually constitute one category that has its basis in chronic interpersonal traumatic events (van der Kolk et al., 1996). The reliability and validity data from this study are consistent with this point of view.

However, the proposed criteria set for the DESNOS construct, although determined by way of empirical cutoffs, suffers some of the same flaws as the other syndromes in the DSM. For example, there are different ways in which an individual can meet the criteria for Complex PTSD/DESNOS, such that two people can have the same diagnosis and yet their manifestation of the disorder may appear to be different. There is heterogeneity in the criteria sets themselves. There is also much overlap between symptoms of DESNOS and other disorders, and thus the issue of whether we are talking about a homogeneous construct or an arrangement of comorbidities is yet to be resolved. The most compelling evidence for the construct are the consistent findings in the literature that the
symptoms of C-PTSD are frequently reported by individuals with childhood maltreatment histories. This appears to be the common thread that ties the symptoms together.

The regression analyses from this study suggest that although C-PTSD has predictive validity in terms of sexual revictimization, it failed (as a unit) to predict physical revictimization. When looking at the components of C-PTSD (as measured in this study), PTSD and somatoform dissociation have the strongest predictive validity in terms of any sexual or physical revictimization, and impaired self-capacities appear to play the strongest predictive role in terms of revictimization within intimate relationships, and of perpetration of sexual violence. If these results are replicated with various samples, and particularly with samples that are randomly selected, it would suggest that the construct may consist of co-morbidities (i.e., may actually be several different constructs that are correlated with each other and have different predictive validities), rather than a homogenous construct that is explained by chronic interpersonal trauma. This argument is somewhat circular, however, in that revictimization is itself a symptom criterion of C-PTSD. On the other hand, it may be that the construct is homogeneous, but takes on different properties depending upon which set of symptoms are predominant for a given individual. That is, there may be different “subsets” of C-PTSD (such as a subset consisting largely of affect dysregulation problems, another subset consisting of somatic and depressive symptoms), and that the subsets have differential predictive validities. The results from this one
study are not sufficient for drawing conclusions on this issue, but compel further study on the construct.

Education

To the extent that individuals with childhood maltreatment histories are at increased risk of revictimization (whether by strangers or by intimate partners) because of the adverse, long-term effects of their earlier maltreatment, such information could be incorporated into educational programs and could effectively decrease victim-blame within larger social settings. Therapists-in-training, medical professionals, legal professionals, and the media, if they come to understand the reasons why these individuals are at increased risk, may concomitantly adopt a more compassionate and less judgmental stance. For example, a police officer who understands that a sexual assault victim did not scream or fight back because she or he was experiencing an automatic conditioned cognitive-emotional-behavioral response (e.g., freezing; submission) based in earlier childhood abuse would in all likelihood experience empathy and interact with the individual in a different manner than if that same police officer believed that the lack of appropriate response to threat was because the victim was consenting.
References


Herman, J.L. (1992b). *Trauma and recovery.* New York: Basic books


APPENDIX A. Recruitment Letters
Recruitment letter for Burnaby Correctional Centre for Women Inmates

Hello:

I am conducting a study for my doctoral research in Counseling Psychology at UBC, under the supervision of Dr. Beth Haverkamp. The purpose of this study is for us to identify the effects of particular experiences that you may have had. In particular, we are interested in finding out if (a) you have experienced certain events; (b) if so, what thoughts, feelings, and behaviors you may have had as a result of those experiences; and (c) if you have had similar experiences during adulthood.

If you decide to participate in the study, you will be asked to complete 7 questionnaires and you will be paid $7.00. The money will be deposited into your account after you have returned the completed questionnaires. I will also need to review your legal records; however, it is important to know that the information will be held completely confidential, and that I will remove any information that could identify you.

Participation in this study will be very helpful to other individuals who have experienced similar events in their lives. The results will be used to help professionals develop effective treatment approaches to help prevent similar events from occurring during adulthood.

It will take approximately 2 hours to complete the questionnaires. If you choose to participate in the study, you are completely free to withdraw or stop at any time. If you withdraw or stop, it will not affect your legal situation or any treatment.

Thank you very much for your time and consideration.

Sincerely,

Anne Dietrich, M.A.
Recruitment Letter for the New Westminster Counselling Center

To Whom It May Concern:

I am conducting a study for my doctoral dissertation in Counseling Psychology at UBC, under the supervision of Dr. Beth Haverkamp. The purpose of this study is for us to identify the effects of particular childhood experiences.

Participation in the study requires that you complete 7 questionnaires. The results will be useful for developing treatment approaches to help prevent similar events from occurring during adulthood.

If you answer “yes” to any of the following questions, you are eligible to participate in the study:

- Prior to age 17, did you ever see a parent or parent surrogate hit or beat up your other parent?
- Prior to age 17, did a parent or surrogate parent regularly yell at you, insult you, criticize you, try to make you feel guilty, ridicule or humiliate you, embarrass you in front of others, and/or make you feel like you were a bad person?
- Prior to age 17, did a parent, surrogate parent or other adult in charge of you ever do something to you on purpose (e.g., hit or punch or cut you, or push you down) that made you bleed or gave you bruises or scratches, or that broke bones or teeth?
- Prior to age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts, when either (a) you did not want it or (b) the person was at least 5 years older than you or (c) the person used force or coercion (including getting you intoxicated or drugging you)?
- Prior to age 17, did anyone ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina, when either (a) you did not want it; or (b) the person was at least 5 years older than you; or (c) the person used force or coercion (including getting you intoxicated or drugging you)?
- To your knowledge, did your parents or parent surrogates fail to meet your physical and/or emotional needs when you were growing up?
- Have you ever experienced the loss of a significant other (e.g., parent or parent surrogate) prior to age 17?
- To the best of your knowledge, before age 17 were you ever sexually abused, physically abused, or neglected?

It will take approximately one to two hours to complete the questionnaires. An honorarium of $20 will be provided to all participants in this study to compensate for the time requirement. If you choose to participate in the study, you are completely free to withdraw or stop at any time. If you withdraw or stop, it will not affect your treatment.

If you would like to participate in the study, please tell the receptionist, and she will give you the questionnaire package to complete. If you would like further information, or if you have any questions or concerns, please contact me or my supervisor, Dr. Haverkamp, at 822-5259.

Thank you very much for your time and consideration.

Sincerely,

Anne Dietrich, M.A.
Recruitment Letter for Correctional Service of Canada Inmates

Hello,

I am conducting a study for my doctoral dissertation in Psychology at UBC. The purpose of this study is for us to identify the effects of particular events that may have occurred to you during childhood. In particular, I am interested in finding out if (a) you have experienced specific events; (b) if so, what effects they might have had on you; (c) if you have had similar experiences during adulthood; and finally (d) if you have ever interacted in a similar way with others during your adult years.

If you decide to participate in this study, you will receive $7.00 (one day's pay) to compensate for the time it takes to complete the questionnaires. To participate in the study, you will be asked to complete 7 questionnaires. It will take about 2 hours or so to complete them. Participation in this study will be very helpful to other individuals who have experienced similar events in their lives, and will help psychologists to design more effective treatment programs.

If you choose to participate in the study, you are completely free to withdraw or stop at any time. If you withdraw or stop, it will not affect your legal situation or any treatment. As part of the research, I will also need to review your legal records. All information that I collect will be confidential, and kept anonymous. All information I collect will be identified only with a number. Your name will be removed from all materials. Participating in the study will not affect your legal situation in any way.

If you would like to participate in the study, please fill out the bottom of this sheet, and have it sent to the psychology department clerk in RRAC. She will arrange for a pass for you to come to V&C to meet with me (probably on January 12th or 19th, 2001) so that I can answer any questions and so that you can fill out the questionnaires if you choose to do so.

Thank you very much for your time and consideration.

Anne Dietrich, M.A.

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Yes, I would like to attend V & C for more information and/or to fill out the questionnaires for Anne Dietrich's study. Please issue me a pass. My name is (please print on the line below). I understand that I am under no obligation to participate in the study.
APPENDIX B. Demographics Information Sheet
Demographics Information (do NOT write your name on this sheet)

Age: ______

Gender:

_____ Male

_____ Female

Race:

_____ Caucasian

_____ Black

_____ Asian

_____ Native Canadian

_____ Hispanic

_____ Other
Crisis Lines

Greater Vancouver: 872-3311
Richmond, Delta 279-7070
Coquitlam, New West, Maple Ridge 540-2221
Abbotsford, Mission 820-1166
South Fraser Region 951-8855

Support Services and Counselling Centers

Burnaby

Burnaby Family Life Institute 659-2200
Cameray Counselling Centre 291-7422
Multicultural Family Support Services Society 436-1025
Path Counselling Center 420-2002

New Westminster

Fraserside Community Services Society 522-3722
New West Counseling Center 525-6651

North Delta

Deltassist Family and Community Services 594-3455

North Shore

Family Services of the North Shore 926-7851

Surrey

Options 596-4321
Sexual Assault Recovery Anonymous (SARA) 584-2626
Surrey Women's Center Society 589-8373

Vancouver

Battered Women's Support Services 687-1867
BC Society for Male Survivors of Sexual Abuse 682-6482
Bountyfull Counselling Society (sliding scale) 255-6626
Domestic Violence Program (VGH) (24 hour) 875-4924
Downtown Eastside Women's Centre 681-8480
Emotions Anonymous 681-5653
Family Services of Greater Vancouver 874-2938
Lesbian and Gay Counselling (sexual abuse) 733-2601
Suicide Attempt Counselling 879-9251
Survivors of Incest Anonymous 876-5071
Vancouver Association for the Survivors of Torture 299-3539
Vancouver Rape Relief 872-8212
Vancouver Society for Male Survivors of Sexual Abuse 682-6482
Women Against Violence Against Women (WAVAW) 255-6344

Principal Investigator: Beth Haverkamp, Ph.D. 822-5259
Co-Investigator: Anne Dietrich, M.A. (student) 822-5259
APPENDIX D. Consent Forms
Consent Form -- Corrections

Principal Investigator: Beth Haverkamp, Ph.D., Department of Counseling Psychology, 822-5259.

Co-Investigator(s): Anne Dietrich, M.A., Department of Counseling Psychology, University of British Columbia, 822-5259. Anne Dietrich is a Ph.D. student at UBC. This research is for her doctoral dissertation in Counseling Psychology, and is being supervised by Dr. Haverkamp.

Purpose: The purpose of this study is to find out if persons who have had certain experiences as children experience certain thoughts, feelings, and behaviors, and if those thoughts, feelings, and behaviors affect them in other ways. In particular, we are trying to find out if certain thoughts, feelings, and behaviors relate to victimization when interacting with other people.

Study Procedures: If you decide to participate in this study, you will be given seven different questionnaires to complete. The first questionnaire asks about different types of childhood experiences that you may have had.

The second questionnaire asks a few more questions about things that may have happened to you, as well as about different thoughts, feelings, and behaviors that may have occurred as a result of those experiences.

The next four questionnaires ask you about different thoughts, feelings, and experiences you may have as an adult. The final questionnaire asks about certain events that may have happened to you as an adult, as well as certain actions that you may have taken as an adult.

As part of the study, the co-investigator will also require access to your corrections records, including your criminal record.

Page 1 of 3

1 CF version: September 3, 2000
The total time required of you will be about 2 hours, when you will be filling out the questionnaires here at the institution. There may be other persons who are taking part in this study in the room, filling out the questionnaires, at the same time. The testing will occur either in the large visiting room, or in the Psychology offices.

Confidentiality: Any information resulting from this research study will be kept strictly confidential, with the exception that the Psychology department will have a copy of the data (with no identifying information on it). All documents will be identified only by code number and kept in a locked filing cabinet at the office of the co-investigator, and a copy will also be kept in a locked filing cabinet of the Psychology Department at Corrections Canada. Data will be entered into computer software and stored on a floppy diskette. The diskette will be stored in a locked filing cabinet in the co-investigator’s office. Participants will not be identified by name in any reports of the completed study.

Remuneration/Compensation: In order to compensate for the time required to participate, each participant will receive an honorarium of $7.00.

Possible Distress: It is possible that you may feel some distress with some of the questions on the questionnaires. This is an expected reaction when people remember unpleasant or painful experiences, and usually subside within several hours. Some people may not feel any distress, which is also an expected reaction. If you feel distressed and wish to speak with someone about how you are feeling, you may request a visit with the duty psychologist, nurse, or other staff member at any time. You will also receive a list of crisis line numbers with the questionnaires.

Contact: If you have any questions or desire further information with respect to this study, you may contact Beth Haverkamp, Ph.D. or Anne Dietrich, M.A. at 822-5259. If you would like a summary of the study when it is finished, you may contact Anne Dietrich at 822-5259.

If you have any concerns about your treatment or rights as a research subject you may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at 822-8598.

Consent:

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time without jeopardy to my legal situation or access to services.

I have received a copy of this consent form for my own records.
I consent to participate in this study.

Subject Signature

Date

Signature of a Witness

Date

Page 3 of 3
Questionnaires
BCCW

Correlates of Child Abuse

Principal Investigator: Beth Haverkamp, Ph.D., Associate Professor, Department of Counseling Psychology, 822-5259.

Co-Investigator(s): Anne Dietrich, M.A., Department of Counseling Psychology, University of British Columbia, 822-5259.

Your participation in this study is entirely voluntary. You are free to withdraw from the study at any time. If you withdraw from the study, it will have absolutely no effect on your receiving treatment or on your legal situation.

It is possible that you may feel some distress with some of the questions on the questionnaires. This is an expected reaction when people remember unpleasant or painful experiences, and usually subside within several hours. Some people may not feel any distress, which is also an expected reaction. If you feel distressed and wish to speak with someone about how you are feeling, you may request a visit with the duty psychologist, nurse, or other staff member.

Do not put your name on the questionnaires. When you have finished the questionnaires, please return them to Tammy McGee. Please write your name on the envelope so you can receive payment. Your name will be removed once payment is made.

Thank you very much for your participation.
Questionnaires
NW Counselling Center and VHHSC

Principal Investigator: Beth Haverkamp, Ph.D., Associate Professor, Department of Counseling Psychology, 822-5259.

Co-Investigator(s): Anne Dietrich, M.A., Department of Counseling Psychology, University of British Columbia, 822-5259. Anne Dietrich is a Ph.D. student at UBC. This research is for her doctoral dissertation in Counseling Psychology, and is being supervised by Dr. Haverkamp.

The purpose of this study is to find out if persons who have had certain experiences as children also experience certain thoughts, feelings, and behaviors, and if those thoughts, feelings, and behaviors affect them in other ways. In particular, we are trying to find out if certain thoughts, feelings, and behaviors relate to victimization during adulthood when interacting with other people.

Your participation in this study will be very important in helping psychologists and other helping professionals in developing new treatment approaches. These treatment approaches will help persons to reduce the chances of getting victimized or revictimized as adults. Your participation will also be very important for helping psychologists identify what happens to increase the chance that some people who had certain childhood experiences will harm other people during adulthood. When those things are identified, it can assist professionals to design effective treatment programs to help people learn how to not relate to other people in these ways.

The first questionnaire asks about different types of childhood experiences that you may have had. The second questionnaire asks a few more questions about things that may have happened to you, as well as about different thoughts, feelings, and behaviors that may have occurred as a result of those experiences. The next four questionnaires ask you about different thoughts, feelings, and experiences you may have had as an adult. The final questionnaire asks about certain events that may have happened to you as an adult, as well as certain actions that you may have taken as an adult.

In order to compensate for the time required to participate, you will receive an honorarium in the amount of $20. The total time required of you will be one to two hours, when you will be filling out the questionnaires here. Any information resulting from this research study will be kept strictly confidential. All documents
will be identified only by code number and kept in a locked filing cabinet. Participants will not be identified by name in any reports of the completed study. Please do not put your name on the questionnaire.

Your participation in this study is entirely voluntary. You are free to withdraw from the study at any time. If you withdraw from the study, it will have absolutely no effect on your receiving treatment.

It is possible that you may feel some distress with some of the questions on the questionnaires. This is an expected reaction when people remember unpleasant or painful experiences, and usually subside within several hours. Some people may not feel any distress, which is also an expected reaction. Enclosed with these questionnaires is a list of crisis line numbers, counselors, and community agencies, in case you wish to talk to someone about how you are feeling.

Completion of the questionnaires means that you have given consent to participate in this study. When you have finished the questionnaires, please return them to the person who gave you the questionnaire package.

Thank you very much for your participation.
AVS
By Anne Dietrich, 2000

The following survey asks about things that may have happened to you as an adult (age 18 and over). Please answer all of the questions that you can, as honestly as possible. Your answers will be kept confidential.

1) As an adult (age 18 and over) how often did the following happen to you in the average year?

<table>
<thead>
<tr>
<th>Never</th>
<th>Once a year</th>
<th>Twice a year</th>
<th>3-5 times a year</th>
<th>6-10 times a year</th>
<th>11-20 times a year</th>
<th>Over 20 times/yr</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

A person who was close to you would:

A) Yell at you  
B) Insult you  
C) Criticize you  
D) Try to make you feel guilty  
E) Ridicule or humiliate you  
F) Embarrass you in front of others  
G) Make you feel like you were a bad person

If yes, who did this?  

2) After age 17, did anyone ever do something to you on purpose (for example, hit or punch or cut you, or push you down) that made you bleed or gave you bruises or scratches, or that broke bones or teeth? Yes  No

If yes, who did this?  
How often after age 17?  
How old were you the first time (after age 17)?  
How old were you the last time (after age 17)?  
Were the authorities (i.e., the police) ever notified? Yes  No  
Were you ever hurt so badly that you had to see a doctor or go to the hospital? Yes  No

3) After you were age 17, did anyone ever kiss you in a sexual way, or touch your body in a sexual way, or make you touch their sexual parts when you did not want it or when you were too intoxicated with alcohol or drugs to be able to give consent? Yes  No

If yes, with who (check all that apply):

___ A family member
Who?  
At what ages after 17?  
How many family members?  
___ A friend
At what ages?  
How many friends?  
___ A stranger
At what ages? __________
How many strangers? __________

___ A teacher, doctor, or other professional who was in a relationship of power to you
Who? ______________________
How many teachers, doctors, or other professionals? ______
At what ages? __________

___ A partner
At what ages? __________
How many partners? ______

___ Someone else not mentioned above
Who? ______________________
At what ages? __________

Did anyone ever use physical force on any of these occasions? Yes No
If yes, who? __________

Overall, about how many times were you kissed or touched in a sexual way or made to touch someone else’s sexual parts when you did not want it or you were too intoxicated to give consent, after the age of 17? ____ times

4) After you were age 17, did anyone ever have oral, anal, or vaginal intercourse with you, or insert a finger or object in your anus or vagina, when you did not want it or when you were too intoxicated with drugs or alcohol to be able to give consent? Yes No

If yes, with who (check all that apply):
___ A friend
    At what ages? __________
___ A stranger
    At what ages? __________
___ A family member
    Who? ______________________
    At what ages? __________
___ A teacher, doctor, or other professional who was in a position of power to you
    Who? ______________________
    At what ages? __________
___ Someone else not mentioned above
    Who? ______________________
    At what ages? __________

Did anyone ever use physical force on any of these occasions? Yes No
If yes, who? __________

About how many times did anyone five or more years older have oral, anal, or vaginal intercourse with you after age 17, or insert a finger or object in your anus or vagina, when you did not want it, or when you were too intoxicated to give consent? ____ times

Overall, how many people (five or more years older than you) did this? ____ people

5) To the best of your knowledge, after age 17, were you ever

Sexually abused or assaulted? Yes No
Physically abused or assaulted? Yes No
6) After the age of 17, did you ever hurt anyone so badly that they had to see a doctor or go to the hospital? Yes  No
   If yes, to whom? ________________________________________________________________
   How often after age 17? ________ times
   How old were you the first time? ________ years
   How old were you the last time (after age 17?) ________ years

After 17, how often in the worst year that you can remember did you hit someone else?

   ______ never  ______ 1-2 times  ______ 3-5 times
   ______ 6-10 times  ______ 11-15 times  ______ 16-20 times
   ______ 21-30 times  ______ 31-50 times  ______ 51-100 times
   ______ 100-200 times  ______ 201-300 times  ______ 300-400 times
   ______ over 400 times

7) After you were age 17, did you ever kiss anyone in a sexual way when they said no or acted like they did not want it or were highly intoxicated, or kiss a child in a sexual way, or an adolescent at least five years younger than yourself? Yes  No

If yes, with whom? (check all that apply):

   __ A friend or acquaintance
       At what ages were you? ______
       At what ages were they? ______
       How many friends/acquaintances? ______

   __ A stranger
       At what ages were you? ______
       At what ages were they? ______
       How many strangers? ______

   __ A family member
       Who? ___________________________
       How many family members? ______
       At what ages were you? ______
       At what ages were they? ______

   __ Partner
       At what ages were you? ______
       At what ages were they? ______
       How many partners? ______

   __ Someone else not mentioned above
       Who? ___________________________
       At what ages were you? ______
       At what ages were they? ______
       How many other people? ______

Did you ever use physical force on any of these occasions? Yes  No
   If yes, with who? ________________________________________________________________

About how many times did you kiss someone in a sexual way when they said no or acted like they did not want it, or they were highly intoxicated, after you were 17? ________ times
8) After you were age 17, did you ever touch anyone’s body in a sexual way, or make them touch your sexual parts, when they said no or acted like they did not want it or were highly intoxicated, or touch a child, or an adolescent at least five years younger than yourself, in a sexual way, or make them touch your sexual parts? Yes__ No__

If yes, with who (check all that apply):
___ A friend or acquaintance
   At what ages were you?_________
   At what ages were they?_________
   __ A stranger
   At what ages were you?_________
   At what ages were they?_________
___ A family member
   Who?___________________________
   At what ages were you?_________
   At what ages were they?_________
___ Partner
   At what ages were you?_________
   At what ages were they?_________
   How many partners?_________
___ Someone else not mentioned above
   Who?___________________________
   At what ages were you?_________
   At what ages were they?_________

Did you ever use physical force on any of these occasions? Yes__ No__

If yes, with who? ____________________________________________

About how many times did you ever touch anyone’s body in a sexual way, or make them touch your sexual parts, when they said no or acted like they did not want it or were highly intoxicated, or touch a child, or an adolescent at least five years younger than yourself, in a sexual way, or make them touch your sexual parts, after you were 17? ______ times

9) After you were age 17, did you ever have oral, anal, or vaginal intercourse with someone, or insert a finger or object in their anus or vagina when they said no or acted like they did not want it or were highly intoxicated, or have oral, anal, or vaginal intercourse with a child or an adolescent at least five years younger than you, or insert a finger or an object in a child’s anus or vagina, or the anus or vagina of an adolescent at least five years younger than you?
   Yes__ No__

If yes, with who (check all that apply):
___ A friend or acquaintance
   At what ages were you?_________
   At what ages were they?_________
   __ A stranger
   At what ages were you?_________
   At what ages were they?_________

A family member
  Who? __________________________
  At what ages were you? __________
  At what ages were they? __________

A partner
  At what ages were you? __________
  At what ages were they? __________

Someone else not mentioned above
  Who? __________________________
  At what ages were you? __________
  At what ages were they? __________

Did you ever use physical force on any of these occasions? Yes__ No__
If yes, with who? _______________________

About how many times did you have oral, anal, or vaginal intercourse with someone after you were 17, or insert a finger or object in their anus or vagina, when they said no or acted like they did not want it or were highly intoxicated? _____ times

About how many times did you have oral, anal, or vaginal intercourse with a child or adolescent at least five years younger than you, after you were 17, or insert a finger or object in their anus or vagina? _____ times

Thank you very much for participating in this study.
Appendix F Correlational Tables (Tables 24 though Table 27)
Table 24

Zero-order Correlations between SIDES-SR Current Scales and Inventory of Altered Self Capacities (IASC) Scales

<table>
<thead>
<tr>
<th></th>
<th>IASC Conflict</th>
<th>IASC Ideal.</th>
<th>IASC Aband.</th>
<th>IASC Influence</th>
<th>IASC Affect Dysreg.</th>
<th>IASC Tension Reduction</th>
<th>IASC Identity Impair.</th>
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</thead>
<tbody>
<tr>
<td>SIDES-SR I</td>
<td>0.45</td>
<td>0.40</td>
<td>0.48</td>
<td>0.41</td>
<td>0.61</td>
<td>0.60</td>
<td>0.53</td>
</tr>
<tr>
<td>SIDES-SR II</td>
<td>0.24</td>
<td>0.24</td>
<td>0.35</td>
<td>0.28</td>
<td>0.44</td>
<td>0.39</td>
<td>0.47</td>
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<tr>
<td>SIDES-SR III</td>
<td>0.34</td>
<td>0.33</td>
<td>0.43</td>
<td>0.37</td>
<td>0.48</td>
<td>0.44</td>
<td>0.49</td>
</tr>
<tr>
<td>SIDES-SR IV</td>
<td>0.49</td>
<td>0.50</td>
<td>0.54</td>
<td>0.38</td>
<td>0.49</td>
<td>0.45</td>
<td>0.44</td>
</tr>
<tr>
<td>SIDES-SR V</td>
<td>0.36</td>
<td>0.33</td>
<td>0.38</td>
<td>0.27</td>
<td>0.42</td>
<td>0.40</td>
<td>0.42</td>
</tr>
<tr>
<td>SIDES-SR VI</td>
<td>0.30</td>
<td>0.34</td>
<td>0.44</td>
<td>0.23</td>
<td>0.44</td>
<td>0.38</td>
<td>0.48</td>
</tr>
</tbody>
</table>

All correlations are significant at p < .01

SIDES-SR I - Affect Dysregulation
SIDES-SR II - Attention/Consciousness
SIDES-SR III- Altered Perceptions of Self
SIDES-SR IV - Altered relationships
SIDES-SR V - Somatization
SIDES-SR VI- Meaning
Table 25

Zero-order Correlations between SIDES-SR Current Scales and Multiscale Dissociation Inventory (MDI) Scales

<table>
<thead>
<tr>
<th></th>
<th>Disengagement</th>
<th>De-realization</th>
<th>Depersonalization</th>
<th>Memory Disturbance</th>
<th>Multiplicity</th>
<th>Emotional Constriction</th>
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<tbody>
<tr>
<td>SIDES-SR I</td>
<td>.38**</td>
<td>.35**</td>
<td>.44**</td>
<td>.37**</td>
<td>.35**</td>
<td>.48**</td>
</tr>
<tr>
<td>SIDES-SR II</td>
<td>.59**</td>
<td>.55**</td>
<td>.56**</td>
<td>.60**</td>
<td>.55**</td>
<td>.45**</td>
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<tr>
<td>SIDES-SR III</td>
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<td>.36**</td>
<td>.40**</td>
<td>.34**</td>
<td>.27**</td>
<td>.38**</td>
</tr>
<tr>
<td>SIDES-SR IV</td>
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<td>.28**</td>
<td>.32**</td>
<td>.12</td>
<td>.34**</td>
</tr>
<tr>
<td>SIDES-SR V</td>
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<td>.42**</td>
<td>.36**</td>
<td>.45**</td>
<td>.31**</td>
<td>.42**</td>
</tr>
<tr>
<td>SIDES-SR VI</td>
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<td>.32**</td>
<td>.19**</td>
<td>.17*</td>
<td>.29*</td>
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</tbody>
</table>

** p < .01; * p < .05

SIDES-SR I - Affect Dysregulation
SIDES-SR II - Attention/Consciousness
SIDES-SR III - Altered Perceptions of Self
SIDES-SR IV - Altered relationships
SIDES-SR V - Somatization
SIDES-SR VI - Meaning
Table 26

Zero-order Correlations between SIDES-SR Current Scales and Cognitive Distortions Scales (CDS)

<table>
<thead>
<tr>
<th></th>
<th>Self Blame</th>
<th>Helplessness</th>
<th>Hopelessness</th>
<th>Preoccupation w/ danger</th>
<th>Self Criticism</th>
</tr>
</thead>
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<tr>
<td>SIDES-SR I</td>
<td>.56</td>
<td>.53</td>
<td>.56</td>
<td>.52</td>
<td>.52</td>
</tr>
<tr>
<td>SIDES-SR II</td>
<td>.48</td>
<td>.35</td>
<td>.35</td>
<td>.39</td>
<td>.47</td>
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<tr>
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<td>.53</td>
<td>.53</td>
<td>.56</td>
<td>.52</td>
<td>.56</td>
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<tr>
<td>SIDES-SR IV</td>
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<td>.56</td>
<td>.54</td>
<td>.56</td>
<td>.45</td>
</tr>
<tr>
<td>SIDES-SR V</td>
<td>.48</td>
<td>.40</td>
<td>.39</td>
<td>.42</td>
<td>.40</td>
</tr>
<tr>
<td>SIDES-SR VI</td>
<td>.45</td>
<td>.58</td>
<td>.65</td>
<td>.51</td>
<td>.56</td>
</tr>
</tbody>
</table>

All correlations are significant at p < .01

SIDES-SR I - Affect Dysregulation
SIDES-SR II - Attention/Consciousness
SIDES-SR III - Altered Perceptions of Self
SIDES-SR IV - Altered relationships
SIDES-SR V - Somatization
SIDES-SR VI - Meaning
Table 27

Zero-order Correlations between SIDES-SR Current Scales and Detailed Assessment of Posttraumatic Stress (DAPS) Subscales

<table>
<thead>
<tr>
<th>Measures</th>
<th>DAPS re-ex</th>
<th>DAPS Avoid</th>
<th>DAPS hyper.</th>
<th>Daps Dissoc</th>
<th>DAPS Subs</th>
<th>DAPS Suic.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIDES-SR I</td>
<td>.46**</td>
<td>.41**</td>
<td>.38**</td>
<td>.26**</td>
<td>.03</td>
<td>50**</td>
</tr>
<tr>
<td>SIDES-SR II</td>
<td>.56**</td>
<td>.51**</td>
<td>.52**</td>
<td>.60**</td>
<td>-.15*</td>
<td>.37**</td>
</tr>
<tr>
<td>SIDES-SR III</td>
<td>.43**</td>
<td>.41**</td>
<td>.39**</td>
<td>.32**</td>
<td>-.03</td>
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<tr>
<td>SIDES-SR IV</td>
<td>.45**</td>
<td>.41**</td>
<td>.40**</td>
<td>.27**</td>
<td>.14*</td>
<td>.31**</td>
</tr>
<tr>
<td>SIDES-SR V</td>
<td>.48**</td>
<td>.42**</td>
<td>.45**</td>
<td>.37**</td>
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<td>SIDES-SR VI</td>
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</table>

*p < .05; ** p < .01

SIDES-SR I - Affect Dysregulation
SIDES-SR II - Attention/Consciousness
SIDES-SR III- Altered Perceptions of Self
SIDES-SR IV - Altered relationships
SIDES-SR V - Somatization
SIDES-SR VI- Meaning
Appendix G  Glossary of Terms

**Acute Stress Disorder (ASD):** symptoms of anxiety, dissociation, re-experiencing symptoms, avoidance, and increased arousal that occur within one month of the onset of a *severe traumatic stressor event*. The symptoms must last for at least 2 days. If they persist beyond four weeks, the individual may meet criteria for Posttraumatic Stress Disorder.

**Alexithymia:** the inability to express emotions using words.

**Associated Features to PTSD:** symptoms and/or behaviors that are frequently observed with individuals who have PTSD. These may include guilt feelings and phobic avoidance resulting in impaired relationships. The associated features to PTSD also include symptoms of *Disorders of Extreme Stress Not Otherwise Specified (DESNOS).*

**Avoidance:** one of the symptom clusters required for a diagnosis of PTSD; the symptoms include efforts to avoid thoughts, feelings or conversations associated with the traumatic event; efforts to avoid activities, places or people that remind the individual of the traumatic event; an inability to recall an important aspect of the event; diminished interest or participation in significant activities; feelings of detachment or estrangement from others; restricted range of feelings; sense of a foreshortened future.
**Borderline Personality Disorder:** a longstanding, pervasive pattern of functioning that involves impulsivity and instability within interpersonal relationships, self-image and affect.

**C-PTSD:** See “Complex PTSD”

**Central Nervous System (CNS):** the brain and spinal cord.

**Comorbidities:** the occurrence of one or more additional disorders that accompany the individual’s primary disorder.

**Complex PTSD:** Conceptualized by Judith Herman, the construct of Complex PTSD refers to more severe forms of PTSD that are often observed with individuals with severe, chronic, interpersonal violent events (e.g., severe childhood abuse, prisoners of war, battered women). According to Herman, the symptoms of Complex PTSD are often misdiagnosed as Borderline Personality Disorder. The construct as originally conceptualized by Herman includes PTSD, affect dysregulation, amnesia and dissociation, altered relationships with others, altered perceptions of self, altered perceptions of the perpetrator, somatic symptoms, and altered philosophies.
Conversion hysteria: physical symptoms that lead to functional impairments in the absence of medical causes; the functional impairments may in some ways resemble neurological symptoms, but do not correspond to what is known about anatomy and physiology. Freud initially thought that his patients with symptoms of hysteria had been sexually abused during childhood; however, he later changed that thesis to the view that unacceptable thoughts, feelings, and impulses are converted into physical symptoms, and that talking about the unacceptable thoughts, feelings and impulses would heal the patient.

CNS: see Central Nervous System

Delayed-onset PTSD: Posttraumatic Stress Disorder symptoms that begin at least six months following the traumatic event.

Depersonalization: the experience of being somehow detached or disconnected from one's body or mental processes. Individuals who are experiencing depersonalization may feel as though they are separate from their bodies and are observing themselves from somewhere else (e.g., from the ceiling).

Depersonalization Disorder: a disorder that is characterized by persistent or recurrent feelings that one is detached from one's mental processes or body; reality testing is intact
Derealization: the experience that the external world or objects are unreal, e.g., as if one were in a dream

DESNOS: See Disorders of Extreme Stress Not Otherwise Specified

Disorders of Extreme Stress Not Otherwise Specified (DESNOS): As conceptualized by van der Kolk and colleagues, DESNOS refers to affect dysregulation, amnesia and dissociation, altered perceptions of self, altered relationships with others, altered perceptions of the perpetrator, somatization, and altered philosophies. This clustering of symptoms is thought to be based in extreme, interpersonal traumatic events. DESNOS and PTSD in conjunction are also referred to as Complex PTSD.

Dissociative Amnesia: the inability to recall important personal information of a traumatic nature that goes beyond ordinary forgetfulness

Dissociative Disorders: refers to disorders in which there is a disconnection between functions that are usually connected, including consciousness, memory, identity, or perception of the environment. Specific dissociative disorders include Dissociative Amnesia, Dissociative Fugue, Dissociative Identity Disorder, Depersonalization Disorder, and Dissociative Disorder Not Otherwise Specified.
**Dissociative Disorder Not Otherwise Specified (DDNOS):** a disorder where dissociative symptoms are predominant but do not meet the criteria for any specific dissociative disorder.

**Dissociative Fugue:** sudden, unexpected travel away from home or work, with an inability to recall one’s past and confusion of one’s identity or adoption of a new identity.

**Dissociative Identity Disorder:** (formerly Multiple Personality Disorder); the presence of two or more distinct identities or personality states that take control of the individual’s behavior and is accompanied by extreme forgetfulness.

**Etiology:** the cause of a disorder or disease.

**Hyperarousal:** One of the symptom clusters for PTSD; includes symptoms of difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; hypervigilance, and/or an exaggerated startle response.

**Hypoarousal:** a state of lowered arousal in response to a stressful event or a memory of a stressful event; may involve “freezing” types of behaviors, reduced alertness, sleepiness/stupor, being dazed, low energy, and so forth.
**Numbing:** a reduced ability or complete inability to feel emotions or physical sensations

**Peritraumatic:** at the time of a traumatic event

**Peritraumatic dissociation:** symptoms of dissociation that occur during and/or immediately following a traumatic event

**Posttraumatic Stress Disorder (PTSD):** A disorder involving *re-experiencing,* *avoidance,* and *hyperarousal* symptoms that occur in response to a *severe traumatic stressor event.* The person must have experienced intense fear, helplessness or horror in response to the traumatic stressor event. The disorder cannot be diagnosed until at least four weeks have passed since the stressor event.

**PTSD:** See Posttraumatic Stress Disorder

**Re-experiencing symptoms:** one of the criteria clusters for the diagnosis of PTSD; includes at least one of the following symptoms: recurrent and intrusive distressing memories of the event or aspects of the event; recurrent, distressing dreams of the event; acting or feeling as if the event were happening again; intense distress when exposed to memories of the trauma or aspects of the
trauma; physiological reactivity on exposure to internal or external cues that remind the individual of the traumatic event

**Repetition compulsion:** as conceptualized by Sigmund Freud, unconsciously repeated (and usually fruitless) attempts to master a previous traumatic event by exposing oneself to the event again

**Severe traumatic stressor event:** an event that involves direct experience of an event involving actual or threatened death or serious injury or threat to physical integrity, or witnessing such an event, or learning about unexpected or violent death, serious harm, or threat of death or injury of a family member or another person close to the individual. Examples may include military combat, violent assault, kidnapping, being held hostage, terrorist attack, torture, incarceration as a prisoner of war, incarceration in a concentration camp, disasters, severe automobile accidents, and diagnosis of a life threatening illness. In children, developmentally inappropriate sexual experiences without threat or injury.

**Silencing the Self:** sacrificing one's own needs in order to preserve a relationship; involves censoring oneself, devaluing their experience, stuffing of anger, being silent. .
Somatization disorder: a disorder involving many symptoms (e.g., pain, gastrointestinal symptoms, sexual symptoms, and symptoms that have similarities to neurological symptoms) but that are not due to any known medical condition; the symptoms that appear to be neurological do not correspond to what is known about physiology and anatomy (e.g., feelings of numbness of the entire hand).

Stroop task: an experimental paradigm in which the individual is presented with names of different colors that are written in different colored inks (e.g., the word BLUE is written in YELLOW ink), and asked to read the word or name the color. When trying to name the color, the meaning of the word tends to influence how quickly the individual responds with the correct color.

Theoretical covering laws: from the Philosophy of Science, covering laws refer to certain kinds of universally true statements from which conclusions may be deduced.