The Prevalence and Psychological Toll of Sexual Revictimization in Marriage

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Introduction

Child sexual abuse (CSA) is a widespread problem, affecting approximately 20% of women and 8% of men (Pereda, Guilera, Forns, & Gómez-Benito, 2009). One well-documented correlate of sexual abuse is the risk for revictimization, which occurs when someone with a history of CSA is again sexually victimized as an adult (Classen, Palesh, & Aggarwal, 2005; Messman-Moore & Long, 2003). Although intimate partners are most often the perpetrators of adult sexual assault (Tjaden & Thoennes, 2000), studies on sexual revictimization have most commonly focused on assaults perpetrated by a stranger or acquaintance. However, results from recent studies with both clinical and non-clinical samples reveal positive associations between a history of sexual abuse and sexual victimization by an intimate partner (e.g., Daigneault, Hébert, & McDuff, 2009; Jaffe, Cranston, & Shadlow, 2012).

Despite indications that revictimization occurs in intimate relationships, it remains unclear whether revictimization occurs specifically in the context of marriage, which involves a legal contract between spouses. If individuals with a history of sexual abuse experience greater risk of sexual assault from spouses, then extrication from such situations may be especially difficult. Nevertheless, the risk of revictimization may not exist at all stages of marriage. The earliest stage of marriage is said to mark a peak of perceived trust and safety among couples, and is characterized by exceptionally high and stable levels of relationship satisfaction (Lavner, Bradbury, & Karney, 2012). Thus, if revictimization occurs at the hands of marital partners in newlywed couples, this this may shed light on a unique and concerning relational context for revictimization.

The primary goal of this study is to determine whether CSA victims are at increased risk for sexual victimization among newlywed couples. Secondarily, we will examine the psychological toll that such revictimization may have, by assessing victims' reports of trauma-related symptoms—a common outcome of multiple victimizations (e.g., Arata, 1999). We expected that for both wives and husbands, those with a history of CSA would experience greater sexual coercion from a spouse during the first year of marriage. We further predicted that experiences of sexual victimization as a child and an adult would interact, such that among women who experienced CSA, the relationship between sexual victimization by a spouse and trauma-related symptoms would be stronger.

Method

Participants

- Participants were 200 newlywed couples (total $N = 400$) recruited from marriage license records in a Midwestern city. Each partner was in his or her first marriage and at least 19 years old (the legal age of majority in Nebraska). Couples had been married between 11 and 15 months at the time of data collection.
- Participants' ages ranged from 19 to 50 ($M = 26.56$, $SD = 4.10$).
- The vast majority (93.3%) identified themselves as European American.

Measures

- **Child sexual abuse.** The 3-item behaviorally-specific Sexual Abuse subscale of the Computer Assisted Maltreatment Inventory (CAMI; DiLillo et al., 2010) and the 5-item Sexual Abuse scale of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) were used to assess for CSA prior to age 18. Two doctoral-level researchers examined responses from both the CAMI and CTQ to create a single dichotomous measure of CSA.
- **Sexual victimization in marriage.** The 7-item sexual coercion subscale of the Revised Conflict Tactics Scale (CTS-2; Straus, Hamby, Boney-McCoy, & Sugarman, 1996) was used to assess sexual coercion victimization of each partner (perpetrated by the other partner) in newlywed couples over the past 12 months. Scores were computed by summing the number of endorsed items, with higher scores indicating more partner aggression. This scoring method gives equal weight to each form of abusive behavior and is not as vulnerable to memory limitations as reporting behavior frequencies. Both the wife and husband reported on their own victimization and perpetration (i.e., the other partner's victimization). To guard against underreporting, the higher score for both partners' victimization experiences was used.
- **Trauma-related symptoms.** The Trauma Symptom Inventory (TSI; Briere, 1995) consists of 100 items assessing frequency of trauma-related sequelae over the prior 6 months on a scale from 1 (*never*) to 4 (*often*). Ten clinical scales and three validity scales can be computed from these items. However, three composite sum scores based on factor analyses (Briere, 1995) that have been used in prior studies (e.g., Messman-Moore, Brown, & Koelsh, 2005; Resick, Nishith, & Griffin, 2003) were used in the present study. The Trauma symptom score is a sum of 34 items representing the Intrusive Experiences, Defensive Avoidance, Dissociation, and Impaired Self-Reference subscales. The Self-Dysfunction symptom score is a sum of 26 items representing the Sexual Concerns, Dysfunctional Sexual Behavior, and Tension-Reduction Behavior subscales. Therefore, Self-Dysfunction symptoms generally refer to sexual-related problems and conflicts, as well as maladaptive attempts to cope with negative affect. Lastly, the Dysphoria score is a sum of 25 items representing the Anger/Irritability, Depression, and Anxious Arousal subscales.

Data Analysis

Actor-Partner Interdependence Models (APIM) were used to examine our hypotheses. APIM account for the interdependent nature of dyadic data and allow for the modeling of actor effects while controlling for partner effects (Kashy & Kenny, 1999; Kenny, 1996). Analyses were conducted under maximum likelihood estimation with robust standard errors using Mplus v. 7 software (Muthén & Muthén, 1998-2012). First, an APIM with history of CSA as a predictor and sexual coercion as an outcome was estimated. Then, we estimated models for each of the three TSI composites in which CSA, sexual coercion victimization, and the interaction between CSA and sexual victimization were predictors. For CSA, 0 indicated no CSA and 1 indicated a history of CSA. Sexual victimization in marriage was centered at its lowest possible value, such that 0 indicated no sexual victimization.

Figure 1. The impact of the interaction between women's CSA and women's sexual coercion victimization on women's trauma symptoms.

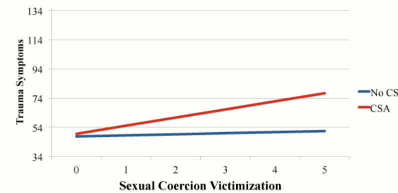


Figure 2. The impact of the interaction between women's CSA and women's sexual coercion victimization on women's self-dysfunction symptoms.

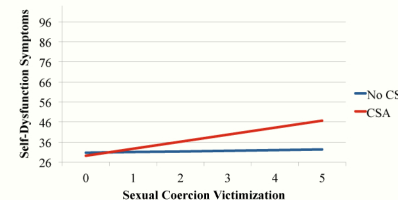
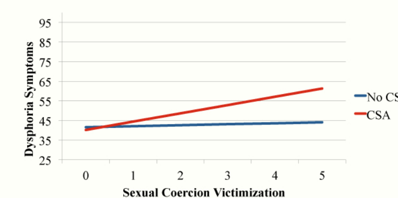


Figure 3. The impact of the interaction between women's CSA and women's sexual coercion victimization on women's dysphoria.



Results

A total of 38 (19%) women and 13 (6.5%) men reported a history of CSA. In four couples (2%), both partners reported a history of CSA. One hundred (50%) women and 82 (42%) men experienced at least one act of sexual coercion by their spouse in the previous year. In 69 couples (34.5%), both partners were reported to be sexually coercive and experience coercion.

CSA and Sexual Victimization

As hypothesized, results indicate that women with a history of CSA experienced more acts of sexual coercion by their husbands during the past year than women without a history of CSA, $b = .62$, $p < .01$. However, among men, a history of CSA was not associated with experiencing sexual coercion in marriage. Results also revealed a significant partner effect, such that the husbands of women with a history of CSA experienced more sexual coercion in marriage ($b = 0.62$, $p < .01$). Men's CSA was not associated with women's sexual coercion.

Trauma Symptoms

Among women, the interaction between women's CSA and women's sexual victimization was a significant predictor of women's TSI symptoms ($b = 4.83$, $p < .01$), suggesting that among women who experienced CSA, the relationship between women's sexual victimization in marriage and trauma symptoms was stronger (see Figure 1). Men with a history of CSA had higher trauma symptoms ($b = 13.93$, $p < .001$) and men's sexual coercion victimization was related to higher trauma symptoms ($b = 5.25$, $p < .01$). However the interaction between men's CSA and men's sexual victimization was not significant.

Self-Dysfunction

For women, the interaction between women's CSA and women's coercion victimization positively predicted women's self-dysfunction symptoms ($b = 3.19$, $p < .01$), suggesting that that among women who experienced CSA, the relationship between women's sexual victimization and self-dysfunction symptoms was stronger (see Figure 2). Men with a history of CSA had higher self-dysfunction symptoms ($b = 5.31$, $p < .05$). However men's sexual coercion victimization and the interaction between men's CSA and men's sexual victimization were not significant in predicting men's self-dysfunction symptoms.

Dysphoria

Among women, the interaction between women's CSA and coercion victimization positively predicted women's dysphoria ($b = 3.72$, $p < .05$), suggesting that that among women who experienced CSA, the relationship between women's sexual victimization and dysphoria was stronger (see Figure 3). Men's sexual coercion victimization was positively related to men's dysphoria ($b = 2.71$, $p < .01$). However men's sexual coercion victimization and the interaction between men's CSA and men's sexual victimization were not significant in predicting men's dysphoria.

Discussion

These results indicate that, for women, sexual revictimization does occur in the early stages of marriage. Although this finding is consistent with prior literature on revictimization in intimate relationships more generally (e.g., Daigneault et al., 2009; Jaffe et al., 2012), this may be the first study to document the risk of revictimization among recently married couples. Given the high levels of satisfaction that typify newlyweds (Lavner et al., 2012), the current findings support the robust nature of the sexual revictimization phenomenon among women.

For men, a history of CSA was not associated with risk for revictimization in marriage. This finding is in contrast to prior studies indicating men are also at risk for sexual revictimization (Desai, Arias, Thompson, & Basile, 2002; Muehlenhard, Highby, Lee, Bryan, & Dodrill, 1998). In the present study, only 13 men endorsed a history of CSA. Although this rate of CSA in men is consistent with prior studies (Pereda et al., 2009), insufficient power may have interfered with our ability to detect risk for revictimization.

When revictimization does occur, it can have a cumulative impact on one's functioning (Classen et al., 2005). Consistent with this prior research, the present findings reveal that in women with a history of CSA, sexual coercion is associated with more severe trauma symptoms, self-dysfunction symptoms, and dysphoria. Although repeated sexual victimization may lead to increased problems in functioning, it is also possible that long-standing trauma-related symptoms contributed to risk for revictimization (e.g., Arata, 2000). Future longitudinal studies could help to clarify the role of trauma-related symptoms in revictimization in marriage.

Overall, these findings are particularly concerning given the high degree of personal and legal commitment involved in marriage. Such patterns of revictimization may continue beyond the first year of marriage, when satisfaction among couples typically decreases (e.g., Lorber, Erlanger, Heyman, & O'Leary, 2014; Mitnik, Heyman, & Smith Slep, 2009), and lead to further exacerbation in wives' trauma symptoms. These findings point to the need for interventions to identify and prevent sexual revictimization in the context of marriage.

This research was supported by a National Institute of Mental Health grant, K01 MH066365-02, awarded to Dr. David DiLillo.